COMMONWEALTH of VIRGINIA
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
600 East Broad Street, Suite 1300
Richmond, VA 23219

April 30, 2008

Dear Prospective Vendor:

The Department of Medical Assistance Services' (DMAS) is soliciting Applications to Contract for Managed Care Organizations (MCOs) to administer a delivery system and arrange for the provision of all services under the Virginia Acute and Long-Term Care (VALTC) program in the Tidewater region. Duties of the MCO shall include providing primary, acute**,** and long-term care services in an integrated, consumer driven managed care system to:

- ensure that recipients receive the appropriate level of care in the least restrictive setting consistent with their personal health, safety and welfare;
- improve access to health care and improve the quality of that care; and
- create accountability and controls on costs and outcomes of care.

The Contractor shall provide, at a minimum, all medically necessary acute care covered services provided under the State Plan for Medical Assistance as found in 12VAC30-50, and further defined by written DMAS regulations, policies and instructions, except as otherwise modified or excluded in this contract, as well as coverage of long-term care services provided under the Elderly or Disabled with Consumer Direction Waiver program.

The Department will implement the VALTC program via an "open contracting" process, i.e., the Department shall contract with all licensed and qualified MCOs, as determined by the Department, in the designated localities. The selected MCOs are not required to participate with the Medallion II or FAMIS programs in order to be eligible to contract under the VALTC program. The first component of the process shall include the Application to Contract, which addresses mandatory requirements that must be met by all interested MCOs. **Applications to Contract for the Tidewater region are due to the Department no later than 2:00 p.m. on May 30, 2008.**

Once the Department enters into contracts with all licensed and qualified MCOs, the MCOs shall be required to show evidence that they can meet additional contracting requirements, including providing updates to the provider network, no later than 2:00 p.m. on August 29, 2008.

Specific details about this contract are in the enclosed document. MCOs must check the DMAS web site at www.dmas.virginia.gov for any addendums or notices.

The Commonwealth shall not pay any costs that any Contractor incurs in preparing an application and reserves the right to reject any and all applications received.

All issues and questions related to this contract should be submitted in writing to the attention of Suzanne Gore, Integrate Care Program Manager, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23219. In order to expedite the process of submitting inquiries, it is requested that vendors submit any questions or issues by email in MS Word format to ALTCMCO@dmas.virginia.gov

Thank you for your continued interest in DMAS' VALTC program. Please continue to check our website, www.dmas.virginia.gov, for any updates on the progress of these programs.

Enclosure

In compliance with this Application to Contract and to all conditions imposed therein and hereby incorporated by reference, the undersigned proposes and agrees to furnish the services contained in their application.

Firm Name (Print)	F.I. or S.S. Number
Address	Print Name
Address	Title
City, State, Zip Code	Signature (Signed in Ink)
Telephone	Date Signed
Fax Number	
Check Applicable Status Corporation ---------- Partnership --------- Proprietorship -------- Individual ------Woman Owned ---------- Minority Owned ---------- Small Business --------- If DMBE certified, provide certification number:	

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

CONTRACT TO PROVIDE INTEGRATED ACUTE AND LONG-TERM CARE SERVICES THROUGH MANAGED CARE ORGANIZATIONS

April 2008

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1. PURPOSE

The Department of Medical Assistance Services (DMAS), hereinafter referred to as the Department or DMAS, is the single State Agency in the Commonwealth of Virginia that administers the Medicaid program under Title XIX of the *Social Security Act* and the Virginia State Child Health Insurance Program, known as the Family Access to Medical Insurance Security (FAMIS), under Title XXI of the *Social Security Act* for low-income people and children. These programs are financed by Federal and State funds and administered by the State according to Federal guidelines.

The Commonwealth of Virginia, Department of Medical Assistance Services, is hereby soliciting applications from licensed and qualified managed care organizations (MCOs) to administer or arrange, under a risk-based managed care contract, integrated acute and long-term care services for adult (age 21 and over) Medicaid recipients enrolled in the Elderly or Disabled with Consumer Direction (EDCD) home-and-community-based waiver or who are classified as full benefit dual eligibles (receiving both Medicaid and Medicare). The Department will enter into contracts with a minimum of two MCOs in the designated region. Prospective MCOs must bid for all targeted populations in the seven (7) core localities within the designated region. MCOs are strongly encouraged to include the provision of services for all targeted populations in the non-core localities as it is the intent of the Department to provide coverage in all targeted localities. However, the Department must have a minimum of two contracted health plans in each of the non-core localities in order to implement the program in those areas. Following evaluation of the applications received, the Department will enter into contracts with all qualifying managed care organizations that meet the requirements outlined within this contract.

FIPS	TIDEWATER
CORE LOCALITIES	
550	Chesapeake
650	Hampton
700	Newport News
710	Norfolk
740	Portsmouth
800	Suffolk
810	Virginia Beach
NON-CORE LOCALITIES	
073	Gloucester
093	Isle Of Wight
095	James City County
199	York
735	Poquoson
830	Williamsburg

Each MCO must have the legal capacity to enter into a contract with the Commonwealth and have a current certificate of authority to operate as a MCO in the Commonwealth of Virginia, as determined by Virginia Bureau of Insurance and Virginia Department of Health.

Applications should be thorough and concise, and include sufficient detail to allow the Department of Medical Assistance Services (DMAS) to properly evaluate the MCO's capacity, capability and relevant experience to perform the work contained within the contract. MCOs also must demonstrate to the Department the financial capacity and relevant expertise necessary to undertake the delivery of health and long-term care services required by this contract. Successful MCOs shall assume financial risk for

developing and managing a health care delivery system that will administer or arrange for the provision of all acute and long-term care covered services to the targeted populations within the designated region. Each MCO must demonstrate its ability to develop a comprehensive provider network to cover the primary, acute and long-term care services for the targeted populations within the proposed service area.

The successful MCO will demonstrate the ability to consistently provide these objectives to the State and will be evaluated, in part, by the degree to which the MCO shows how it will achieve them. The MCO shall perform all services under this contract. The MCO shall comply with all applicable administrative rules and the Department's written policies and procedures, as may be amended from time to time. Copies of such rules and policies are available from the Department.

Number of Awards: An MCO must submit an application for all acute and long-term care services for all targeted populations in all localities within the designated region. Based on the applications, DMAS is planning to select and enter into a contract with licensed and qualified managed care organizations for the provision of acute and long-term care services.

Volume and Participation:

As of 2/1/08	Full Dual	Dual With EDCD	EDCD Only	Total
Tidewater	**12,003**	**1,732**	**371**	**14,106***

*Actuarial estimates based on estimated member continuous months

Tidewater by FIPS	Full Dual	Dual with EDCD	EDCD Only	Total
Gloucester	339	33	15	387
Isle Of Wight	409	67	21	497
James City	300	21	15	336
York	204	18	15	237
Chesapeake	1,544	109	91	1,744
Hampton	1,310	95	49	1,454
Newport News	2,070	174	67	2,311
Norfolk	3,501	328	153	3,982
Poquoson	43	2	7	52
Portsmouth	1,593	134	80	1,807
Suffolk	1,150	147	66	1,363
Virginia Beach	2,467	177	164	2,808
Williamsburg	88	9	6	103
Totals	**15,018**	**1,314**	**749**	**17,081****

**Totals based on point-in-time data as of 04/15/08

The MCO shall be responsible for all acute and long-term care services provided to adult (age 21 and over) Medicaid recipients in designated regions who are enrolled in the Elderly or Disabled with

Consumer Direction (EDCD) home-and-community-based waiver, or classified as full benefit dual eligibles (Medicaid and Medicare). Any newborn enrollee whose mother is a VALTC Medicaid enrollee enrolled in the MCO's plan on his or her date of birth shall be deemed an enrollee of that MCO's plan for up to three calendar months (birth month plus 2 months). MCOs shall be responsible for all child related services to include EPSDT for newborns 0 – 3 months old.

The MCO shall not be responsible for the provision of carved out services provided to MCO enrollees, i.e., the subset of Medicaid covered services which are not covered under the MCO program. Carved out services include such services as dental, community mental health rehabilitation services, transition services, and targeted case management services.

All recipients under the age of 21 or recipients in the Mental Retardation, Day Support, HIV/AIDS, Individual and Family Developmental Disability Support, Alzheimer's and Technology Assisted waiver programs shall not be included in this fully integrated system of care at this time.

1.1 VALTC Mission and Goals

Mission Statement: *To improve the quality of life of Virginia's Medicaid-enrolled seniors and adults with disabilities by empowering them to remain independent and reside in the setting of their choice for as long as possible through the provision of a streamlined primary, acute, and long-term care service delivery system that offers ongoing access to quality health and long-term care services, care coordination, and referrals to appropriate community resources.*

Goals:

- To provide administrative simplification by streamlining the primary, acute and long-term care service delivery system allowing enrollees to easily maneuver through the system.
- To offer timely access to quality health and long-term care service providers.
- To assure the quality of the integrated care program via established performance measures.
- To increase client and family satisfaction with the delivery of health and long-term care services provided to Medicaid-enrolled seniors and individuals with disabilities.
- To offer coordinated managed care for seniors and individuals with disabilities from the well to the frail. The focus will be on providing the "right services at the right time" and eliminating healthcare delivery systems based solely on funding sources and the need for long-term care services.
- To integrate the full range of Medicaid benefits (and Medicare benefits for those that are dually eligible) into a coordinated delivery system for seniors and individuals with disabilities to utilize resources more effectively, improve outcomes, achieve cost containment goals, and enhance budget predictability.
- To include all services available in the Medicaid Managed Care program (except certain carved out services), limited nursing facility care, and the full range of home-and-community-based care programs services under the EDCD waiver (to included consumer-directed services), as well as all the Medicare covered services.

2. BACKGROUND

2.1 Current Managed Care Delivery Model

The Virginia Medicaid program relies on both managed care organizations (MCO) and fee-for-service (FFS) arrangements to provide health care services to Medicaid, FAMIS Plus, and FAMIS recipients. Although FAMIS is not a Medicaid program, it is provided through both the FFS and MCO delivery systems.

Under the current managed care program, the Department contracts with MCOs licensed by the Virginia Bureau of Insurance and that also meet all DMAS MCO Contract requirements. DMAS pays MCOs prospectively on a "per member per month" fee (capitated payment) through a full risk contract to manage the majority of the recipients' health care services.

MCOs assume the full risk for all Medicaid covered benefits and must also provide a number of additional services, including the following: providing or arranging access to medically necessary health services for their members; providing member services and 24-hour nurse advice lines, care management, and care coordination; maintaining a provider network; processing provider claims, including assuring adequate and timely reimbursement; assuring quality of care; providing to the Department all required reports and documentation of performance; and participating in annual reviews conducted by the DMAS contracted external quality review organization (EQRO).

2.2 Integrated Care Delivery Models

Governor Timothy Kaine, with support from the 2006 General Assembly, set in motion a major reform of the Virginia Medicaid funded long-term care services program, which will focus on care coordination and integration of acute and long-term care services for our most vulnerable citizens—low-income seniors and individuals with disabilities. The legislation (*Special Session I, 2006 Virginia Acts of Assembly, Chapter 3*) directed the Department of Medical Assistance Services (DMAS), in consultation with the appropriate stakeholders, to develop a long range blueprint for the development and implementation of an integrated acute and long-term care system. In addition to this plan, the Department was directed to move forward with two different models for the integration of acute and long-term care services: a community model and a regional model, which are explained below and in the body of the report. Finally, the legislation provided $1.5 million in start-up funds for six potential Program of All-Inclusive Care for the Elderly (PACE) sites.

While Virginia has been successful in implementing managed care for low-income children and families, it has not applied the same successful principles to programs specifically designed for the long-term care populations. Currently in Virginia, most Medicaid seniors and individuals with disabilities receive acute and long-term care services through a patchwork of fragmented health and social programs that are not necessarily responsive to individual consumer needs. Acute care is provided in a fee-for-service environment with no chronic care management. Long-term care is provided in a nursing facility or by a variety of home-and-community-based care providers with no overall care coordination or case management and no assigned primary care providers. In addition, most Medicaid seniors and individuals with disabilities qualify for both Medicare and Medicaid, which further complicates the access, quality, and funding of an integrated system.

The regional model will be a capitated system for all acute and long-term care services. Unlike the PACE model, where all health care professionals and all services center around an Adult Day Health Care Center, a regional model utilizes a variety of community health care providers. By design, regional models will coordinate the care needs of both seniors and individuals with disabilities and are not limited

to only those with long-term care needs. DMAS intends to move forward with a regional model in two phases. More information can be found on the DMAS website at http://www.dmas.virginia.gov/altc-home.htm

2.2.1 Community Model – PACE

The community model is the Program of All Inclusive Care for the Elderly (PACE). PACE serves persons 55 and older who meet nursing facility criteria. All health and long-term care services are provided in the community, centered around an adult day health care model, and with Medicaid and Medicare funding combined. This is a voluntary program and is a community alternative to nursing facility care. There are currently three PACE sites in the Commonwealth: Sentara in the Virginia Beach Area, Riverside of Hampton, and Mountain Empire Older Citizens, a rural PACE site in the far Southwest. Appalachian Area Agency on Aging will go live with PACE in early May 2008 and plans are underway for PACE sites in the Lynchburg and Richmond areas.

DMAS intends to move forward with the community model in two phases. Phase I is the completion of implementation of seven full PACE sites across the Commonwealth. Additional phases will be determined by the Department.

2.2.2 Regional Model – Virginia Acute and Long-Term Care Integration Program (VALTC)

Phase I: Virginia is one state that advanced forward with moving seniors and individuals with disabilities into managed care years ago. At the present time, more than 49,000 elderly and disabled have their health care needs successfully managed by one of five managed care organizations (MCOs) across Virginia. However, once these recipients need long-term care services and/or become both Medicaid and Medicare eligible (known as dual eligibles), they are moved out of a managed care environment into a fee for service environment with little coordination of their health care and long-term care needs. This disruption in care is not good for the enrollee and is costly for the Commonwealth. In response to the above mentioned legislation, DMAS implemented a program that expanded its current managed care population by retaining those enrollees in managed care once they require long-term care services.

Effective September 1, 2007, once the enrollee is approved for long-term care services (excluding those enrollees receiving Technology Assisted Waiver, nursing facility, and PACE services); they remain in the MCO for their primary and acute medical care services. Their home-and-community-based care waiver services, including transportation to the waivered services, are paid through the Medicaid fee for service program. This program change does not address the dual eligibles, and nursing facility residents; all services for these enrollees will still be moved out of managed care when they become eligible for those services. Phase I impacts approximately 500 enrollees per year.

Phase II: This phase entails integrating managed care and long-term care to offer participants better coordination and quality of care. To accomplish this, DMAS is integrating populations and services previously excluded from managed care into managed care. The goal of integrated care is to provide the right service at the right time to the right person and to make appropriate services more accessible to participants. Studies of existing managed long-term care programs have been largely positive and indicate high consumer satisfaction levels, lower utilization of institutional services, and increased utilization of home-and-community-based services.

The VALTC program will be piloted in Tidewater and the greater Richmond area (implementation in Richmond will be late 2009). The new populations will be:

1) Adult (age 21 and over) participants who are eligible for both Medicare and Medicaid (full benefit duals only – not to include individuals on spend down); and
2) Adult (age 21 and over) participants in the Elderly or Disabled with Consumer Direction (EDCD) waiver.

Recipients in the HIV/AIDS, Mental Retardation, Day Support, Developmental Disabilities, Alzheimers, and Technology Assisted Waivers will be excluded at this time, as will recipients under the age of 21 who are full benefit duals or participating in the EDCD waiver.

The new services that will be covered include:

a. EDCD waiver services: adult day health care, personal care (consumer-and agency-directed), respite services (consumer-and agency-directed), and personal emergency response system (PERS). In July 2008, the following services will be added to the EDCD waiver: assistive technology, environmental modifications, certain transition coordination and transition services (as a carved-out service).

b. Sixty (60) days of a nursing facility stay.

c. Medicare services to include coinsurance, copayment, and deductible for Medicare-allowed services (i.e., "crossover claims") and Medicaid-covered services, including those not covered Medicare.

2.3 Federal Authority

The Department is seeking Federal approval of this program from the Centers for Medicare and Medicaid Services (CMS) via the 1915(b) managed care waiver and an amendment to the 1915(c) EDCD home-and-community-based waiver.

2.4 Definitions

Abuse (Program) - (i) use of health services by recipients which is inconsistent with sound fiscal or medical practices and that results in unnecessary costs to the Virginia Medicaid program or in reimbursement for a level of use or a pattern of services that is not medically necessary, or (ii) provider practices which are inconsistent with sound fiscal or medical practices and that result in (a) unnecessary costs to the Virginia Medicaid program, or (b) reimbursement for a level of use or a pattern of services that is not medically necessary or that fails to meet professionally recognized standards for health care.

Abuse (Recipient) - the infliction of injury, unreasonable confinement, intimidation, punishment, mental anguish, sexual abuse or exploitation of a participant. Types of abuse include: a) physical abuse (a physical act by an participant that may cause physical injury to another participant); b) psychological abuse (an act, other than verbal, that may inflict emotional harm, invoke fear and/or humiliate, intimidate, degrade or demean an participant); c) sexual abuse (an act or attempted act such as rape, incest, sexual molestation, sexual exploitation or sexual harassment and/or inappropriate or unwanted touching of an participant by another); and d) verbal abuse (using words to threaten, coerce, intimidate, degrade, demean, harass, or humiliate an participant).

Accreditation –The process of evaluating an organization against a set number of measures of performance, quality, and outcomes by a recognized industry standard accrediting agency. The accrediting agency certifies compliance with the criteria, assures quality and integrity, and offers purchasers and members a standard of comparison in evaluating health care organizations.

Activities of Daily Living (ADLs) - Personal care tasks that are generally performed on a daily basis (i.e., bathing, dressing, toileting, transferring, bowel/bladder control, and eating/feeding). An individual's degree of independence in performing these activities is a part of determining appropriate level of care and services.

Actuarially Sound Capitation Rates – As defined in 42CFR 438.6 means capitation rates that have been developed in accordance with generally accepted actuarial principles and practices; are appropriate for the populations to be covered and the services to be furnished under the contract; and have been certified as actuarially sound by actuaries who meet the qualification standards established by the American Academy of Actuaries and follow the practice standards established by the Actuarial Standards Board.

Acute Care - Preventive care, primary care, and other medical care provided under the direction of a physician for a condition having a relatively short duration.

Adult Day Health Care Center (ADHC) - Agency provider that offers a community-based day program providing a variety of health, therapeutic, and social services designed to meet the specialized needs of vulnerable adults at risk of placement in a nursing facility. The ADHC must be licensed by the Virginia Department of Social Services.

Adult Day Health Care Services - Services designed to prevent institutionalization by providing participants with health, maintenance, and coordination of rehabilitation services in a congregate daytime setting.

Adverse Action (Medicaid Only) - Consistent with 42 CFR § 438.400, is an action by the MCO, subcontractor, service provider or Department, that constitutes a denial or limited authorization of a service authorization request, including the type or level of service; or reduction, suspension, or termination of a previously authorized service; or denial in whole or in part of a payment for a covered service for an enrolled member; or failure by the MCO to render a decision within the required timeframes; or the denial of an enrollee's request to exercise his right under 42 CFR 438.52(b)(2)(ii) to obtain services outside of the network.

Agency-Directed Services - Services provided by an Agency provider who is responsible for directing and managing services in accordance with an individual's service plan.

Agency Provider - A public or private organization/entity that holds a Medicaid provider contract and furnishes services to waiver participants using its own employees or subcontractors.

Annually – For the purposes of contract reporting requirements, annually shall be defined as within 90 calendar days of the effective contract date and effective contract renewal date.

Appeal (Medicaid Only) - In accordance with 42 CFR 438.400, an appeal is defined as a request for review of an adverse action, as defined in this contract. An appeal is an enrollee's challenge to the adverse actions regarding services, benefits, and reimbursement provided by the contractor, its subcontractors and service providers or the Department of Medical Assistance Services (also referred to herein as "the Department"). An appeal may also be filed against the MCO by its sub-contractors and service providers, for adverse actions.

Assess - To evaluate an individual's condition, including social supports, health status, functional status, psychosocial history, and environment. Information is collected from the individual, family, significant others, and medical professionals, as well as the assessor's observation of the individual.

Assessment - One or more processes that are used to obtain information about an individual, including his or her condition, personal goals and preferences, functional limitations, health status, and other factors that are relevant to the authorization and provision of services. Assessment information supports the determination that an individual requires waiver services as well as the development of the service plan.

Assisted Living - The provision to residents of personal care and other assistance as needed with ADLs and instrumental ADLs, but does not provide round-the-clock skilled nursing services.

Assisted Living Facility (ALF) - A congregate residential setting as defined in §63.2-100 of the *Code of Virginia*, as amended.

Assistive Technology - Specialized medical equipment and supplies including those devices, controls, or appliances specified in the service plan, but not available under the State Plan for Medical Assistance, that enable individuals to increase their abilities to perform ADLs and/or to perceive, control, or communicate with the environment in which they live or that are necessary for the proper functioning of the specialized equipment and are cost-effective and appropriate for the individual's assessed needs.

Attendant - An individual who provides consumer-directed personal assistance services. This term is also used to describe persons who provide respite services through consumer-directed waiver services.

Atypical Provider Identification Number (API) – Atypical Providers are individuals or organizations that are <u>not</u> defined as healthcare providers under the National Provider Identifier (NPI) Final Rule. Atypical providers may supply non-healthcare services such as non-emergency transportation or carpentry. The Department of Medical Assistance Services (DMAS) assigns an Atypical Provider Identifier (API) to providers who are not eligible to receive an NPI. Examples of Atypical Providers are Adult Day Health Care, Non-Emergency Transportation, Assisted Living Personal Care, Case Management Respite Care, Family Caregiver Training, Treatment Foster Care, and Mental Retardation /Mental Health Services (non-health care).

Audit - An audit refers to a formal review of compliance with a particular set of internal (e.g., policies and procedures) or external (e.g., laws and regulations) standards used as base measures.

Balanced Budget Act – Refers to the Balanced Budget Act (BBA) of 1997; final rule issued June 14, 2002; effective August 13, 2002. The BBA is the comprehensive revision to Federal statutes governing all aspects of Medicaid managed care programs as set forth in section 1932 of the Social Security Act and Title 42 Code of Federal Regulations (CFR) Part 438 et. seq.

Business Days – Means Monday through Friday, 8:00 AM to 5:00 PM, Eastern Standard Time, unless otherwise stated.

Capitation Payment - A payment the Department makes periodically to a MCO on behalf of each recipient enrolled under a contract for the provision of acute and long-term care services under the State Plan, regardless of whether the particular recipient receives services during the period covered by the fee.

Capitation Rate - The monthly amount, payable to the MCO, per enrollee, for all expenses (acute and long-term care) incurred by the MCO in the provision of contract services as defined herein.

Caregiver - A person who helps care for someone who is ill, has a disability, and/or has functional limitations and requires assistance. Informal caregivers are relatives, friends, or others who volunteer their help. Paid caregivers provide services in exchange for payment for the services rendered.

Carved-Out Services - The subset of Medicaid covered services which the MCO shall not be responsible for covering under the program.

Care Management – Assessing and planning of services; linking the individual to services and supports identified in the service plan; assisting the individual directly for the purpose of locating, developing, or obtaining needed services and resources; coordinating services and service planning with other agencies and providers involved with the individual; making collateral contacts to promote the implementation of the service plan and community integration; monitoring to assess ongoing progress and ensuring services are delivered; and education and counseling that guides the individual and develops a supportive relationship that promotes the service plan. Care management may be referred to as "care coordination," "service coordination," "support coordination" or "health care coordination."

Centers for Medicare and Medicaid Services (CMS) –The Federal agency of the United States Department of Health and Human Services that is responsible for the administration of Title XIX and Title XXI of the Social Security Act.

Claim – An itemized statement of services rendered by health care providers (such as hospitals, physicians, dentists, etc.), billed electronically or on the HCFA 1500 or UB-92.

Clean Claim - A claim that has no defect or impropriety (including any lack of any required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payments from being made on the claim under this title. See sections 1816(c)(2)(B) and 1842(c)(2)(B) of the Social Security Act.

Client, Recipient, Enrollee, Member or Participant - Any individual having current Medicaid eligibility who shall be authorized by the Department to participate in the VALTC program.

CMS Assurance – They key indicators that CMS uses to determine if a state is meeting its contractual obligations as defined in the waiver.

Cold Call Marketing – Any unsolicited personal contact with a potential enrollee by an employee, affiliated provider or contractor of the entity for the purpose of influencing enrollment with such entity.

Community-Based Care Waiver Services or "Waiver Services" - A variety of home- and community-based services paid for by DMAS as authorized under a §1915(c) waiver designed to offer individuals an alternative to institutionalization. Individuals may be preauthorized to receive one or more of these services either solely or in combination, based on the documented need for the service or services to avoid nursing facility or ICF/MR placement.

Complaint – A grievance.

Comprehensive Assessment - The gathering of relevant social, psychological, medical, and level of care information by the care coordinator and is used as a basis for the development of the service plan.

Consumer Assessment of Health Plans Survey (CAHPS™) – A consumer satisfaction survey developed collaboratively by Harvard, RAND, the Agency for Health Care Policy and Research, the Research Triangle Institute, and Westat that has been adopted as the industry standard by NCQA and CMS to measure the quality of managed care plans.

Consumer-Directed (CD) Employee - A person who is employed by the individual receiving CD services or their representative to provide approved services (e.g., personal care, companion services, and/or respite care), who is exempt in Virginia from Workers' Compensation.

Consumer-Directed Services - Services for which the individual or their representative, as appropriate, is responsible for directing their own care and hiring, training, supervising, and firing of staff.

Consumer-Directed (CD) Services Facilitator (SF) - The Agency provider who is responsible for supporting the individual or their representative, as appropriate, by ensuring the developing and monitoring of the service plan, providing employee management training, and completing ongoing review activities as required by DMAS for consumer-directed personal care and respite services.

Contract - The signed and executed document resulting from this contract, including all attachments or documents incorporated by reference.

Cost Sharing – Co-payments paid by the enrollee in order to receive medical services.

Covered Services - The subset of Medicaid services which the MCO shall be responsible for covering under the program.

Credentialing - The process of collecting, assessing, and validating qualifications and other relevant information pertaining to a health care provider to determine eligibility and to deliver Covered Services.

Cultural Competency- A competency based on the premise of respect for individuals and cultural differences, and an implementation of a trust-promoting method of inquiry and assistance.

Current Functional Status - An individual's degree of dependency in performing activities of daily living.

Data Analysis - Tool for identifying potential payment errors and trends in utilization, referral patterns, formulary changes, and other indicators of potential fraud, waste or abuse. Data analysis compares claim information and other related data to identify potential errors and /or potential fraud by claim individually or in the aggregate. Data analysis is an integrated, on-going component of fraud detection and prevention activity.

Department - The Virginia Department of Medical Assistance Services.

Disease Management – System of coordinated healthcare interventions and communications for populations with conditions in which patient self-care efforts are significant.

Disenrollment - The process of changing enrollment from one VALTC MCO plan to another VALTC MCO.

DMAS-122 Form - The Patient Information Form, which is used to exchange information regarding the responsibility of a Medicaid-eligible individual to make payment toward the cost of services or other information that may affect the eligibility status of an individual.

Dual Eligibles - Medicare beneficiaries who are also enrolled in the Medicaid program. These beneficiaries are eligible for prescription drug coverage through the Medicare Part D program that began on January 1, 2006.

Drug Efficacy Study Implementation (DESI) – Drugs for which DMAS will not provide reimbursement because the drugs have been determined by the Food and Drug Administration (FDA) to lack substantial evidence of effectiveness.

Early Intervention – As defined in the Virginia Code § 2.2-5300, are those services provided through Part C of the Individuals with Disabilities Education Act (20 U.S.C. § 1431 et seq.), as amended, designed to meet the developmental needs of each child and the needs of the family related to enhancing the child's development and provided to children from birth to age three who have (i) a twenty-five percent developmental delay in one or more areas of development, (ii) atypical development, or (iii) a handicapping condition. The MCO shall cover medically necessary services, including rehabilitative therapies within the amount duration and scope as defined in 12VAC30-130-10 and 12VAC30-50-200. All services shall be specific and provide effective treatment for the patient's condition in accordance with accepted standards of medical practice. This includes the requirement that the amount, frequency, and duration of the services shall be reasonable.

Elderly Or Disabled With Consumer Direction Waiver (EDCD) - The CMS-approved 1915(c) waiver that covers a range of community support services offered to individuals who are elderly or who have a disability who would otherwise require a nursing facility level of care.

Emergency Medical Condition - A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent lay person, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to body functions, or serious dysfunction of any bodily organ or part.

Emergency Room Assessment Fee (Triage Fee) - The fee paid for all non-emergency claims for services delivered in the emergency room. The fee has two (2) components: a facility component and a physician component. The facility component is reimbursed using an all-inclusive fee that approximates the fee for an intermediate emergency room visit. The physician component is reimbursed using an all-inclusive fee that approximates the fee for a brief physician office visit for a new patient.

Emergency Services - Those health care services that are rendered by participating or non-participating providers, after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1. Placing the client's health or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy;
2. Serious impairment to bodily functions; or,
3. Serious dysfunction of any bodily organ or part.

Employer - The individual who directs their own care and receives CD services from an attendant who is hired, trained, and supervised by the individual or the individual's representative.

Encounter – Any covered or enhanced service received by an Enrollee through the MCO or its subcontractor.

Encounter Data – Data collected by the managed care plans documenting all of the health care and related services provided to a Medicaid member. These services include, but are not limited to, professional services, medical supplies or equipment and medications. Encounter data is collected on an individual member level and includes the person's Medicaid ID number. It is also specific in terms of the

provider, the medical procedure, and the date the service was provided. DMAS and the Federal government require MCOs to collect and report this data. Encounter data is a critical element of measuring managed care plan's performance and holding them accountable to specific standards for health care quality, access, and administrative procedures.

Encryption – A security measure process involving the conversion of data into a format which cannot be interpreted by outside parties.

Enhanced Services - Services offered by the MCO to enrollees in addition to covered services. The Department will not pay for enhanced services.

Enrollee - A person eligible for Medicaid who is enrolled with a VALTC MCO to receive services under the provisions of this contract.

Enrollee Handbook – Document required by the contract to be provided by the MCO to the enrollee prior to the first day of the month in which their enrollment starts. The handbook must include all of the following sections: table of contents, enrollee eligibility, choosing or changing an MCO, choosing or changing a PCP, making appointments and accessing care, enrollee services, emergency care, enrollee identification cards, enrollee responsibilities, MCO responsibilities, grievances (complaints), and appeals, translation services, and program or site changes.

Enrollment (Managed Care) - The completion of approved enrollment forms by or on behalf of an eligible person and assignment of a recipient to a VALTC MCO by the Department in accordance with the terms of this contract.

Enrollment (Waiver) - The process where an individual has been determined to meet the eligibility requirements (financial and functional) for a program or service and the approving entity has verified the availability of services for that individual. It is used to define the entry of an individual into a home- and community-based waiver program.

Enrollment Area - The counties and municipalities in which an eligible organization is authorized by the Commonwealth of Virginia, pursuant to a contract, to operate as a MCO and in which service capability exists as defined by the Commonwealth.

Enrollment Broker - An independent broker who enrolls recipients in the MCO plan and who is responsible for the operation and documentation of a toll-free recipient service helpline. The responsibilities of the enrollment broker include, but are not limited to, recipient education and enrollment, assistance with and tracking of recipient's grievance resolution, and may include recipient marketing and outreach.

Enrollment Period – The time that a recipient is enrolled in a Department approved MCO during which they may not disenroll or change MCOs unless disenrolled under one of the conditions described in this document and pursuant with Section 1932 (a)(4)(A) of Title XIX. This period may not exceed twelve months.

Environmental Modifications - Physical adaptations to a house, place of residence, primary vehicle or work site (when the work site modification exceeds reasonable accommodation requirements of the Americans with Disabilities Act) that are necessary to ensure the individual's health and safety or enable functioning with greater independence. The adaptation may not be used to bring a substandard dwelling up to minimum habitation standards and must be of direct medical or remedial benefit to the individual.

Excluded Entity - Any provider or subcontractor that is excluded from participating in the MCO's health plan as defined in Section 7.1, of this contract.

Exclusion from VALTC Program - The removal of an enrollee from the program on a temporary or permanent basis.

Expedited Appeal –The process by which an MCO must respond to an appeal by a recipient if a denial of care decision by an MCO may jeopardize life, health or ability to regain maximum function. The decision must be rendered within three (3) business days of the recipient appeal.

External Quality Review (EQR) – Analysis and evaluation by an EQRO, of aggregated information on quality, timeliness, and access to the health care services that a MCO or their contractors furnish to Medicaid recipients, as defined in 42 CFR 438.320.

External Quality Review Organization (EQRO) – An organization that meets the competence and independence requirements set forth in 42 CFR 438.354 and performs external quality review, and other EQR related activities as set forth in 42 CFR 438.358.

Family Planning – Those services necessary that delay or prevent pregnancy. Coverage of such services shall not include services to treat infertility or services to promote fertility.

Federally Qualified Health Centers (FQHCs) - Those facilities as defined in 42 C.F.R. § 405.2401(b), as amended.

Fee-for-Service - The traditional health care payment system in which physicians and other providers receive a payment for each unit of service they provide. This method of reimbursement is not used by the Department to reimburse the MCO under the terms of this contract.

Fiscal/Employer Agent (F/EA)- An organization operating under Section 3504 of the IRS Code and IRS Revenue Procedure 70-6 and Notice 2003-70 which has a separate Federal Employer Identification Number used for the sole purpose of filing federal employment tax forms and payments on behalf of program individuals who are receiving consumer-directed services.

Flesch Readability Formula - The formula by which readability of documents is tested as set forth in Rudolf Flesch, *The Art of Readable Writing* (1949, as revised 1974).

Formulary – A list of drugs that the MCO has approved. Prescribing some of the drugs may require prior authorization.

Fraud - Intentional deception or misrepresentation made by a person or entity with the knowledge that the deception could result in payment of an unauthorized benefit.

Generally Accepted Accounting Principles (GAAP) - Uniform minimum standards of and guidelines to financial accounting and reporting as established by the Financial Accounting Standards Board and the Governmental Accounting Standards Board.

Grievance - In accordance with 42 CFR § 438.400, grievance means an expression of dissatisfaction about any matter other than an "action." Grievance is also used to refer to the overall system that includes grievances and appeals handled at the MCO level and access to the State fair hearing process. (Possible subjects for grievances include, but are not limited to, the quality of care or services provided and aspects

of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights.)

Guardian – A person who is legally responsible for the care and management of a minor child or an adult.

Health Insurance Portability & Accountability Act of 1996 (HIPAA) - Title II of HIPAA requires standardization of electronic patient health, administrative and financial data; unique health identifiers for individuals, employers, health plans, and health care providers; and security standards protecting the confidentiality and integrity of individually identifiable health information past, present, or future.

Home-and-Community-Based Waiver Services - The range of community support services approved by CMS pursuant to § 1915(c) of the Social Security Act to be offered to persons who are elderly or who have a disability and who would otherwise require the level of care provided in an institutional setting. DMAS or the designated preauthorization contractor shall give preauthorization for Medicaid reimbursed home-and community-based care.

Home Health Aide - A person who, under the supervision of a home health agency, assists persons who are elderly, ill, or a person with a disability with household chores, bathing, personal care, and other daily needs.

Home Health Services - The provision of part-time or intermittent nursing care and home health aide services and other services as determined by the State, that are provided to Medicaid beneficiaries in their place of residence. Home health services must be ordered by a physician as part of the individual's service plan.

Hospital - A facility that meets the requirements of 42 C.F.R. § 482, as amended.

Individual Service Plan (ISP) - The service plan related solely to the specific waiver service. Multiple ISPs comprise the overall service plan.

Informational Materials – Written communications from the MCO to enrollees that educates and informs enrollees about services, policies, procedures, or programs specifically related to Medicaid.

Inquiry – An oral or written communication usually received by a Member Services Department or telephone help line representative made by or on the behalf of a member that may be: 1) questions regarding the need for additional information about eligibility, benefits, plan requirement or materials received, etc., 2) provision of information regarding a change in the member's status such as address, family composition, etc., or 3) a request for assistance such as selecting or changing a PCP assignment, obtaining translation or transportation assistance, obtaining access to care, etc. Inquiries are not expressions of dissatisfaction.

Instrumental Activities of Daily Living (IADLs) - Activities related to independent living, including meal preparation, shopping, housekeeping, laundry and money management. The extent to which an individual requires assistance in performing these activities is assessed in conjunction with the evaluation of level of care.

Intensive Outpatient Services – Services shall include the major psychiatric, psychological and psycho-educational modalities to include: individual, group counseling and family therapy; education about the effects of alcohol and other drugs on the physical, emotional, and social functioning of the individual; relapse prevention; occupational and recreational therapy, or other therapies. Intensive outpatient services

for recipients are provided in a nonresidential setting and shall be provided in sessions of two or more consecutive hours per day, which may be scheduled multiple times per week, to provide a minimum of 4 hours and a maximum of 19 hours of skilled treatment services per week.

Laboratory - Any laboratory performing testing for the purpose of providing information for the diagnosis, prevention, or treatment of disease or impairment, or the assessment of the health of human beings, and which meets the requirements of 42 C.F.R. § 493.3, as amended.

Level of Care (LOC) - The specification of the minimum amount of assistance that an individual must require in order to receive services in an institutional setting under the State Plan.

Level of Functioning (LOF) - A measure of a client's functioning in community environments. The environments assessed are health status, communication ability, task learning skills, personal/self care, mobility, behavior, and community living skills.

Long-Term Care - A variety of services that assist individuals with health or personal needs and activities and instrumental activities of daily living over a period of time. Long-term care can be provided at home, in the community, or in various types of facilities, including nursing facilities and assisted living facilities.

Managed Care Organization (MCO) – An organization which offers managed care health insurance plans (MCHIP), as defined by Virginia Code § 38.2-5800, which means an arrangement for the delivery of health care in which a health carrier undertakes to provide, arrange for, pay for, or reimburse any of the costs of health care services for a covered person on a prepaid or insured basis which (i) contains one or more incentive arrangements, including any credentialing requirements intended to influence the cost or level of health care services between the health carrier and one or more providers with respect to the delivery of health care services and (ii) requires or creates benefit payment differential incentives for covered persons to use providers that are directly or indirectly managed, owned, under contract with or employed by the health carrier. Any health maintenance organization as defined in § 38.2-4300 or health carrier that offers preferred provider contracts or policies as defined in § 38.2-3407 or preferred provider subscription contracts as defined in § 38.2-4209 shall be deemed to be offering one or more MCHIPs. For the purposes of this definition, the prohibition of balance billing by a provider shall not be deemed a benefit payment differential incentive for covered persons to use providers who are directly or indirectly managed, owned, under contract with or employed by the health carrier. A single managed care health insurance plan may encompass multiple products and multiple types of benefit payment differentials; however, a single managed care health insurance plan shall encompass only one provider network or set of provider networks. Additionally, for the purposes of this Contract, and in accordance with 42 CFR 438.2, means an entity that has qualified to provide the services covered under this Contract to qualifying VALTC enrollees as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid recipients within the area served, and meets the solvency standards of 42 CFR 438.116.

Marketing Materials - Any materials that are produced in any medium, by or on behalf of an MCO; are used by the MCO to communicate with individuals who are not its enrollees; and can reasonably be interpreted as intended to influence the individuals to enroll or reenroll in that particular MCO and entity.

Marketing Services - Any communication, services rendered or activities conducted by the MCO or its subcontractors to its prospective enrollees for the purpose of education or providing information that can reasonably be interpreted as intended to influence the recipient to enroll in that particular MCO's Medicaid product.

Medicaid Covered Services - Services as defined in the Virginia State Plan for Medical Assistance or State regulations.

Medicaid Fraud Control Unit - The unit established within the Office of the Attorney General to audit and investigate providers of services furnished under the Virginia State Plan for Medical Assistance, as provided for in the Code of Virginia § 32.1-320, as amended.

Medicaid Management Information System (MMIS) - The medical assistance and payment information system of the Virginia Department of Medical Assistance Services.

Medicaid Non-Covered Services - Services not covered by DMAS and, therefore, not included in covered services as defined in the Virginia State Plan for Medical Assistance or State regulations.

Medicaid Recipient - Any individual enrolled in the Virginia Medicaid program.

Medical Necessity - "Medical necessity" or "medically necessary" means appropriate and necessary health care services which are rendered for any condition which, according to generally accepted principles of good medical practice, requires the diagnosis or direct care and treatment of an illness, injury, or pregnancy-related condition, and are not provided only as a convenience. As defined in 42 C.F.R. § 440.230, services must be sufficient in amount, duration and scope to reasonably achieve their purpose.

Medication Monitoring - An electronic device that is only available in conjunction with Personal Emergency Response Systems that enables individuals at risk of institutionalization to be reminded to take their medications at the correct dosages and times.

Medicare Crossover Claim - A Medicare-allowed claim for a dual eligible recipient for payment of coinsurance, deductible, and copayment.

Modifications to Contract - Any changes or modifications to the contract that are mutually agreed to in writing by the MCO and the Department or are mandated by changes in Federal or State laws or regulations.

Money Follows the Person ("MFP") - Demonstration project designed to create a system of long-term services and supports that better enable individuals to transition from certain long-term care institutions into the community. To participate in MFP, participants must: 1) have lived for at least six (6) months in a nursing facility, an intermediate care facility for individuals with mental retardation, or a long-stay hospital licensed in Virginia; and 2) plan to move to a qualified community-based residence. Individuals may participate in MFP for up to twelve (12) months.

Monitoring - The ongoing oversight of the provision of waiver and other services to determine that they are furnished according to the individual's service plan and effectively meet his or her needs, including assuring health and welfare. Monitoring activities may include, but are not limited to, telephone contact, observation, interviewing the individual and/or the individual's family, as appropriate, and in person or by telephone, and/or interviewing service providers.

Monthly – For the purposes of reporting requirements, monthly shall be defined as the 15th day of each month for the prior month's reporting period. For example, January's monthly reports are due by February 15th; February's are due by March 15th, etc.

National Provider Identifier (NPI) - NPI is a national health identifier for all typical health care providers, as defined by CMS. The NPI is a numeric 10-digit identifier, consisting of 9 numbers plus a check-digit It is accommodated in all electronic standard transactions and many paper transactions. The assigned NPI does not expire.

Network Provider - The health care entity or health care professional who is either employed by or has executed a contract with the MCO, or its subcontractor, to render covered services, as defined in this contract, to enrollees.

Newborn Guarantee Coverage Period - The time period between the date of birth of a child whose mother is a Medicaid enrollee with the VALTC MCO until the last day of the third calendar month including the month of birth, unless otherwise specified by the Department. For example, a baby born any day in February will be enrolled with the VALTC MCO until April 30.

Non-participating Provider - A health care entity or health care professional not in the MCO's participating provider network.

Nursing Facility – "Certified nursing facility" - Any skilled nursing facility, skilled care facility, intermediate care facility, nursing or nursing care facility, or nursing facility, whether freestanding or a portion of a freestanding medical care facility, that is certified for participation as a Medicare or Medicaid provider, or both, pursuant to Title XVIII and Title XIX of the United States Social Security Act, as amended, and § 32.1-137.

Open Enrollment – Time frame defined by CMS and the Department as 60 calendar days prior to the end of the recipient's MCO enrollment. Before this 60-day time frame, recipients must be notified of their ability to disenroll or change plans at the end of their enrollment period.

Opt-out - Moving from VALTC MCO to fee-for-service. Allowed only if the individual meets Department criteria.

Out-of-Network Coverage - Coverage provided outside of the established MCO network; medical or long-term care services rendered to an enrollee by a provider not affiliated with the MCO or contracted with the MCO.

PACE – The Program of All-inclusive Care for the Elderly. PACE provides the entire spectrum of health and long-term care services (preventive, primary, acute and long-term care services) to their enrollees without limit as to duration or dollars.

Party in Interest - Any director, officer, partner, agent, or employee responsible for management or administration of the contract; any person who is directly or indirectly the beneficial owner of more than five (5) percent of the equity of the MCO; any person who is the beneficial owner of a mortgage, deed of trust, note, or other interest secured by and valuing more than five (5) percent of the MCO; or, in the case of a MCO organized as a nonprofit corporation or other nonprofit organization, an incorporation or enrollee of such corporation under applicable State corporation law. Additionally, any organization in which a person previously described is a director, officer or partner, that has directly or indirectly a beneficial interest of more than five (5) percent of the equity of the MCO or has a mortgage, deed of trust, note, or other interest valuing more than five (5) percent of the assets of the MCO; any person directly or indirectly controlling, controlled by, or under common control with the MCO; or any spouse, child, or parent of a previously described individual.

Patient Pay - A Medicaid recipient's financial responsibility toward his or her cost of care. The patient pay amount must be applied to the cost of care. The balance of the charge for services, after the patient pay amount is subtracted from the total charge, is the responsibility of the Virginia Medical Assistance Program up to the rate allowed under the payment system. The Patient Information Form (DMAS-122) is the document used by local Department of Social Services (DSS) offices to identify a patient's Medicaid eligibility status and to notify the Medicaid provider of the amount of the individual's financial responsibility toward his/her cost of care. This form must be on file for all Medicaid recipients.

Person with Ownership or Control Interest - A person or corporation that owns, directly or indirectly, five (5) percent or more of the MCO's capital or stock or received five (5) percent of the total assets of the MCO in any mortgage, deed of trust, note, or other obligation secured in whole or in part by the MCO or by its property or assets, or is an officer, director, or partner of the MCO.

Personal Care Services - Long-term maintenance or support services necessary to enable the individual to remain at or return home rather than enter a nursing facility. Personal care services are provided to individuals in the areas of activities of daily living, access to the community, monitoring of self-administered medications or other medical needs, and the monitoring of health status and physical condition. Where the individual requires assistance with activities of daily living, and where specified in the plan of care, such supportive services may include assistance with instrumental activities of daily living. Services may be provided in home and community settings to enable an individual to maintain the health status and functional skills necessary to live in the community or participate in community activities. Supervision is an allowable component of personal care pursuant to the guidelines outlined in the EDCD Provider Manual.

Personal Care Provider – Agency provider that renders services to prevent or reduce more costly institutional care by providing eligible individuals with personal care attendants to provide personal care services and has a provider contract with DMAS.

Person-Centered Planning - A process, directed by the individual or their family/caregiver, as appropriate, with long-term care needs, intended to identify the strengths, capacities, preferences, needs and desired outcomes of the individual.

Personal Emergency Response System (PERS) - An electronic device and monitoring service that enable certain individuals at risk of institutionalization to secure help in an emergency. PERS services are limited to those individuals who live alone or are alone for significant parts of the day and who have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.

PERS Provider - An entity that meets the standards and requirements set forth by DMAS to provide PERS equipment, direct services, and PERS monitoring. PERS providers may also provide medication monitoring.

Plan Of Care – A written document outlining the objectives and activities planned to assist in meeting the recipient's service goals.

Post Stabilization Services – Covered services related to an emergency medical condition that are provided after an enrollee is stabilized in order to maintain the stabilized condition or to improve or resolve the enrollee's condition.

Potential Enrollee – A Medicaid recipient who is subject to mandatory enrollment in a given managed care program. [42CFR438.10(a)]

Preadmission Screening (PAS) - The process to: (i) evaluate the functional, nursing, and social supports of individuals referred for preadmission screening; (ii) assist individuals in determining what specific services the individuals need; (iii) evaluate whether a service or a combination of existing community services are available to meet the individuals' needs; and (iv) refer individuals to the appropriate provider for Medicaid-funded facility or home- and community-based care.

Preadmission Screening (PAS) Team - The entity contracted with DMAS that is responsible for performing preadmission screening pursuant to the *Code of Virginia* , § 32.1-330.

Previously Authorized – As described in 42 CFR 438.420, in relation to continuation of benefits, previously authorized means a prior approved course of treatment, and is best clarified by the following example. If the MCO authorizes 20 visits and then later reduces this authorization to 10 visits, this exemplifies a "previously authorized service" that is being reduced. Conversely, "previously authorized" does not include the example whereby (1) the MCO authorizes 10 visits; (2) the 10 visits are rendered; and (3) another 10 visits are requested but are denied by the MCO. In this case, the fact that the MCO had authorized 10 visits on a prior request for authorization is not germane to continuation of benefits requirements for previously authorized services that are terminated, suspended or reduced.

Primary Care Provider (PCP) - A practitioner who provides preventive and primary medical care for eligible recipients and who certifies prior authorizations and referrals for all medically necessary specialty services. PCPs may include pediatricians, family and general practitioners, internists, obstetrician/gynecologists, and specialists who perform primary care functions such as surgeons, clinics including, but not limited to, health departments, Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), etc.

Primary Caregiver - The primary person who consistently assumes the role of providing direct care and support of the individual to live successfully in the community without compensation for providing such care.

Protected Health Information (PHI) - Individually identifiable information, including demographics, which relates to a person's health, health care, or payment for health care. HIPAA protects individually identifiable health information transmitted or maintained in any form or medium.

Quarterly – For the purposes of reporting requirements, quarterly shall be defined as within 30 calendar days after the end of each calendar quarter.

Quarters - Calendar quarters starting on January 1, April 1, July 1, and October 1.

Reevaluation - The periodic, but at least annual, review of an individual's condition and service needs to determine whether the individual continues to need a level of care specified in the waiver.

Respite Care - Services provided for the unpaid caregivers of eligible individuals who are unable to care for themselves and are provided on an episodic or routine basis because of the absence of or need for relief of those unpaid persons.

Respite Care Provider - Agency provider that renders services designed to provide periodic or routine relief for unpaid caregivers.

Rural Health Clinic - A facility as defined in 42 C.F.R. § 491.2, as amended.

Service Authorization Request – A managed care enrollee's request for the provision of a service.

Service Plan - The written document that specifies the waiver and other services (regardless of funding source) along with an informal supports that are furnished to meet the needs of and to assist a waiver participant to remain in the community. The service plan must contain, at a minimum, the types of services to be furnished, the amount, the frequency, and duration of each service, and the type of provider to furnish each services. "Service plan" is synonymous with the term "plan of care."

Skilled Nursing Services - Nursing services listed in the service plan that do not meet home health criteria, required to prevent institutionalization, not otherwise available under the State Plan for Medical Assistance, are provided within the scope of the state's Nurse Practice Act and Drug Control Act (Chapters 30 (§54.1-3000 *et seq*.) and 34 (§54.1-3400 *et seq*.), respectively), and provided by a registered professional nurse, or by a licensed practical nurse under the supervision of a registered professional nurse, in each case who is licensed to practice in the Commonwealth. Skilled nursing services are to be used as training, consultation, nurse delegation, as appropriate), and oversight of direct care staff, as appropriate.

State Fair Hearing – The Department's evidentiary hearing process. Any "action" or appeal decision rendered by the MCO may be appealed by the enrollee to the DMAS Client Appeals Division. The Department conducts evidentiary hearings in accordance with regulations at 42 CFR § 431.200 through 431.250 and 12 VAC30-110-10 through 12VAC30-110-380.

State Plan for Medical Assistance (State Plan) - The comprehensive written statement submitted to CMS by the Department describing the nature and scope of the Virginia Medicaid program and giving assurance that it will be administered in conformity with the requirements, standards, procedures and conditions for obtaining Federal financial participation. The Department has the authority to administer the State Plan for Virginia under Code of Virginia § 32.1-325, as amended.

Subcontract - A written contract between the MCO and a third party, under which the third party performs any one or more of the MCO's obligations or functional responsibilities under this contract.

Subcontractor - A State approved entity that contracts with the MCO to perform part of the MCO's responsibilities under this contract. For the purposes of this contract, the subcontractor's providers shall also be considered providers of the MCO.

Substance Abuse – The use of drugs, without a compelling medical reason or alcohol that (i) results in psychological or physiological dependence or danger to self or others as a function of continued and compulsive use or (ii) results in mental, emotional, or physical impairment that causes socially dysfunctional or socially disordering behavior and (iii), because of such substance abuse, requires care and treatment for the health of the individual. This care and treatment may include counseling, rehabilitation, or medical or psychiatric care.

Successor Law or Regulation - That section of Federal or State law or regulation which replaces any specific law or regulation cited in this contract. The successor law or regulation shall be that same law or regulation if changes in numbering occur and no other changes occur to the appropriate cite. In the event that any law or regulation cited in this contract is amended, changed or repealed, the applicable successor law or regulation shall be determined and applied by the Department in its sole discretion. The Department may apply any source of law to succeed any other source of law. The Department shall provide the MCO written notification of determination of successor law or regulation.

Temporary Detention Order (TDO) - An emergency custody order by sworn petition to any magistrate to take into custody a person believed to be mentally ill and in need of hospitalization and transported to a

location to be evaluated pursuant to 42 C.F.R. 441.150 and Code of Virginia, 16.1- 335 et. seq. and 37.1-67.1 et seq.

Third-Party Liability (TPL) - Any entity (including other government programs or insurance) which is or may be liable to pay all or part of the medical cost for injury, disease, or disability of an applicant or recipient of Medicaid.

Transition Services - Services that are set-up expenses for individuals who are transitioning from an institution or licensed or certified provider-operated living arrangement to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses. For the purposes of transition services, an institution means an ICF/MR, a nursing facility, or a specialized care facility/hospital as defined at 42CFR435.1009. Transition services do not apply to an acute care admission to a hospital.

Urban Area - Places of 2,500 or more persons incorporated as cities, villages, boroughs, and towns but excluding the rural portions of "extended cities" according to the US Department of Commerce, Bureau of the Census.

Urgent Medical Condition - A medical (physical, mental, or dental) condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of medical attention within twenty-four (24) hours could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to result in:

a. Placing the patient's health in serious jeopardy;
b. Serious impairment to bodily function;
c. Serious dysfunction of any bodily organ or part; or
d. In the case of a pregnant woman, serious jeopardy to the health of the fetus.

Utilization Management – The process of evaluating the necessity, appropriateness and efficiency of health care services against established guidelines and criteria.

Value-Added Network (VAN) - A third party entity (e.g. vendor) that provides hardware and/or software communication services, which meet the security standards of telecommunication.

Virginia Uniform Assessment Instrument (UAI) - The standardized multidimensional questionnaire that assesses an individual's psychosocial, physical health, mental health, and functional abilities to determine if an individual meets level of care criteria for long-term care services.

3. SCOPE OF SERVICES

Section 3 of the contract is designed to provide MCOs with sufficient information to understand the MCOs' responsibilities and describes scope of work requirements. The MCO must possess a current certificate of authority to operate as an MCO in the Commonwealth of Virginia, as determined by Virginia Bureau of Insurance and Virginia Department of Health in all cities/counties within the designated region, and verification from CMS of the MCO's active status as a Medicare Advantage Plan with Prescription Drug Plan (MA-PDP) or Medicare Special Needs Plan (SNP). Coverage for benefits shall be available to enrolled recipients effective on the implementation start date. The implementation start date is anticipated to be February 1, 2009.

The MCO must comply, to the satisfaction of DMAS, with (1) all provisions set forth in this contract and (2) all applicable provisions of Federal and State laws, rules, regulations, and waivers. The Department reserves the right to consider, approve, and/or reject all delivery model options consistent with

Department goals, Federal and State regulatory requirements, and the requirements described in this contract.

3.1 Changes to Population or Services

DMAS will notify the MCO of any additions or deletions of programs and/or populations and services and its projected impact on payment at least 90 days prior to the effective date of the addition or deletion of programs and/or populations or services. Any changes in populations and/or services shall be handled via the contract change process outlined in Section 10.14 of this contract and the capitation rate development process.

4. APPLICATION TO CONTRACT – MANDATORY REQUIREMENTS

This section contains the mandatory requirements for the Application to Contract. The MCO shall provide detailed evidence to demonstrate compliance with the mandatory tasks listed in this section. When preparing the applications, MCOs must address the concerns and requirements addressed in Section 4.1 and submit supporting materials specified by **2:00 p.m. May 30, 2008**. MCOs shall follow submission guidelines as outlined in Section 8 of this contract. All communications with DMAS regarding this contract should be directed to the principal point of contact as listed in Section 8. All contract content-related questions shall be in writing to the principal point of contact.

4.1 Mandatory Requirements to Conduct Business

The successful MCO must be able to meet the following requirements. MCOs shall indicate their understanding and ability to perform these tasks in their Application to Contract to the Department due by **2:00 p.m. May 30, 2008**. In order to enter into a contract with the Department of Medical Assistance Services for the provision of managed long-term care services, the following information must be submitted as part of the MCO's Mandatory Requirements response:

4.1.1 Financial, management, and administrative capabilities

a. A copy of the valid and current license (not under suspension or revocation) from the Virginia State Corporation Commission's Bureau of Insurance, and copies of quarterly and annual filings submitted to the BOI within the past two calendar years. The MCO must retain at all times during the period of the contract the appropriate licensure. For MCO delivery models, this includes licensure by the State Corporation Commission as set forth in the Code of Virginia §38.2-4300 through 38.2-4323, 14 AC5-210-10 et. seq. and any and all other applicable laws of the Commonwealth of Virginia, as amended.

b. Verification (approved and current contract with CMS for the designated localities) from CMS of the MCO's active status as a Medicare Advantage Plan with Prescription Drug Plan (PDP) or Medicare Special Needs Plan in the seven core localities and optional localities.

c. Copy of service area approval and certificate issued by the Center for Quality Health Care Services and Consumer Protection. Pursuant to §32.1-137.1 through §32.137.7 Code of Virginia, and 12VAC5-408-10 et. seq., all managed care health insurance plan licensees must obtain service area approval certification and remain certified by the State Health Commissioner Center for Quality Health Care Services and Consumer Protection to confirm the quality of health care services they deliver.

d. A description of the MCO's experience working with special needs populations who may also be dual eligibles, elderly, have visual impairments, and/or have disabilities.

4.1.2 Quality improvement and utilization management processes

Verification of the MCO's Medicaid national accreditation status through NCQA or URAC. The MCO must demonstrate its ability to retain accreditation. If the MCO is not accredited, the MCO must provide documentation that the organization is in the process of acquiring accreditation, i.e., scheduled for a site review, prior to February 1, 2009. In response to this contract, the MCO must report to the Department any deficiencies noted within the previous year by NCQA or URAC.

4.1.3 Network of providers with appropriate demographic placement and specialties

a. A listing in Microsoft Excel, in hard copy and CD, of all potential VALTC providers (acute and long-term care) within their network. For the purposes of this application, MCOs shall submit letters of intent as well as any existing members of their acute and long-term care provider network (commercial, Medicaid and/or Medicare) which the plan believes will participate in the VALTC program. Column headings shall be those listed below:
    i. Provider First name
    ii. Provider Last name
    iii. Provider type, example: Hospital, Specialist, PCP, Home Health, Personal Care, Adult Day Health Care, etc. (if internal company abbreviations are used, supply a cross reference)
    iv. Provider specialty, example: Anesthesiologist, OB/GYN, Pediatrician, etc. (if internal company abbreviations are used, supply a cross reference)
    v. City, State, Zip of the physical office location NOT the billing/payment location
    vi. County (can use City/County codes as defined in Section 1)
    vii. Office telephone number
    viii. Tax ID number
    ix. National Provider Identifier (NPI) or API, if applicable
    x. Additional language abilities (other than English)
    xi. Status of contract (letter of intent or signed contract)

4.1.4 Informational programs for enrollees and consumer protections

The MCO's proposed marketing and informational plan, consistent with 42CFR438 parts 10 (informational requirements) and 104 (allowable marketing activities). MCO's application must include a description of the informational services which it will make available to enrollees, including telephone and or web-based help lines, translation services, educational classes, and other services, as relevant. MCO shall include proposed written plan for health education and prevention.

4.1.5 Ability to process information and data, and render appropriate reports quickly, efficiently, and completely

a. A description of the MCO's process and procedures for incorporating assigned enrollees into their client base. Include a clear statement of the maximum number of enrollees the MCO is capable of enrolling and will be prepared to enroll during the first year of the contract.

b. A description of the management information systems the MCO will have in place to comply with the Department or its MCO's encounter data submission requirements more fully described in Section 5. Reference Encounter Data Submissions Manual at http://www.dmas.virginia.gov/downloads/pdfs/mc_Encounter_dataManual.pdf

4.1.6 HIPAA confidentiality requirements

MCO's assurance of compliance with DMAS HIPAA confidentiality requirements as described in Section 11.16 of this contract. MCOs must indicate their understanding and ability to perform these tasks.

5. CONTRACT FOR SERVICES

Qualified MCOs that enter into a contract with DMAS shall be required to show evidence that they can meet the additional contracting requirements, including providing updates to the provider network, no later than **2:00 p.m. on August 29, 2008**. MCOs shall follow submission guidelines as outlined in Section 8 of this contract.

The MCO shall have technical, organizational and professional capability to assume the responsibility for the implementation of a process for managing the scope and volume of work contained in this contract. The narrative shall demonstrate that the MCO has considered all the requirements and has developed a specific approach to meeting them in order to implement a successful project. It is not sufficient to state that the requirements will be met. The description shall correspond to the order of the tasks described herein. The MCO may perform all of these processes internally or involve subcontractors for any portion. Subcontractors shall be identified by name and by a description of the services/functions they will be performing. The MCO shall be wholly responsible for the performance of this entire contract whether or not subcontractors are used.

MCOs are encouraged to be creative in how these tasks are accomplished. MCOs may add additional tasks in their application or suggest an alternate task to replace a task described below and how the alternate task will meet the same objective as appropriate (and as approved by the Department).

5.1 Program Population Description

The Department is implementing the mandatory managed care program that provides for a comprehensive package of medical and long-term care benefits to the following recipients age 21 and over if they meet the Medicaid financial and non-financial eligibility requirements:

- Existing and newly enrolled Elderly or Disabled with Consumer Direction (EDCD) waiver: The CMS-approved waiver that covers a range of community support services offered to individuals who are elderly or who have a disability who would otherwise require a nursing facility level of care. Home-and-community-based waiver services shall be available through a §1915(c) of the Social Security Act waiver for the following Medicaid-eligible individuals who have been determined to be eligible for waiver services and to require the level of care provided in an institutional setting:
  1. Individuals who are elderly as defined by §1614 of the Social Security Act; or
  2. Individuals who are disabled as defined by §1614 of the Social Security Act.

  Participants receive Medicaid primary and acute care services along with the following home-and-community-based long-term care services:
  - adult day health care,
  - personal care (both consumer- and agency-directed),
  - respite services (both consumer-directed, agency-directed, and facility-based),
  - skilled respite services
  - personal emergency response system (PERS),
  - service facilitation (to assist individuals who wish to consumer direct services),
  - assistive technology,
  - environmental modifications, and
  - transition services and transition coordination (as carved-out services).

  More information about the EDCD Waiver may be found in the provider manual on the DMAS website at http://websrvr.dmas.virginia.gov/manuals/edcd/edcd.htm.

- Existing and newly enrolled full benefit dual eligibles: individuals enrolled in Medicare and eligible for Medicaid coverage. These recipients are included in the Virginia Administrative Code as "Qualified Medicare Beneficiaries (QMB) Plus." This program will not include individuals who are required to "spend down" income in order to meet Medicaid eligibility requirements. This program also will not include "non" full benefit dual eligibles such as:
  - Qualified Medicare Beneficiaries (QMBs),
  - Special Low Income Medicare Beneficiaries (SLMBs),
  - Qualified Disabled Working Individuals (QDWIs), or
  - Qualified Individuals (QI).

  These are individuals for whom DMAS only pays a limited amount each month toward their cost of care (e.g., deductibles).
  Dual eligibles may receive Medicaid coverage for the following:
  - Medicare monthly premiums for Part A, Part B, or both.
  - Coinsurance, copayment, and deductible for Medicare-allowed services.
  - Medicaid-covered services, including those that are not covered by Medicare.

- Existing and newly enrolled full benefit dual eligibles receiving EDCD Waiver services: Some individuals are eligible for both Medicare and the EDCD waiver and will receive services as noted above.

- Any newborn enrollee whose mother is a VALTC Medicaid enrollee enrolled in the MCO's plan on his or her date of birth shall be deemed an enrollee of that MCO's plan for up to three calendar months (birth month plus 2 months). MCOs shall be responsible for all child related services to include EPSDT for newborns 0 – 3 months old.

5.2 Responsibilities of the Department

The Department shall be responsible for the administration and monitoring of this contract. Administration of the contract shall be conducted in good faith within the resources of the State, but in the best interest of the enrollees. The Department shall retain full authority for the administration and monitoring of the Medicaid Program in accordance with the requirements of all applicable Federal and State laws and regulations. Specifically, the Department shall:

- Establish and define the medical and long-term care benefits to be provided by the health plan;
- Develop the rules, policies, regulations, and procedures governing the VALTC program;
- Negotiate and enter into a contract with the health plan;
- Determine initial and continued eligibility of VALTC enrollees;
- Enroll and disenroll members;
- Review and monitor the adequacy of the health plan's provider networks;
- Monitor the quality assessment and performance improvement programs of the health plan and providers;
- Review and analyze utilization of services and reports provided by the health plan;
- Oversee the State Administrative Hearing processes;
- Monitor the financial status of the programs;
- Analyze the VALTC program to ensure that it is meeting the stated objectives;
- Provide member information to the health plan;
- Oversee the activities of the enrollment broker to whom the State delegates the responsibilities of assisting people in selecting a health plan and educating new members;

- Oversee the activities of other State contracts, including but not limited to the enrollment broker contractor, EQRO, etc.;
- Review and approve the health plan's marketing materials;
- Conduct the readiness review as described in Section 5.2.3 and Section 5.47;
- Impose civil or administrative monetary penalties and/or financial sanctions for violations or health plan non-compliance with contract provisions;
- Report criminal conviction information disclosed by providers and report provider application denials pursuant to 42 CFR Part455.106(b);
- Meet CMS requirements for the 1915(b) and 1915(c) waivers;
- Refer member and provider fraud cases to appropriate law enforcement agencies; and
- Coordinate with and monitor fraud and abuse activities of the health plan.

5.2.1 Contract administration

The Department shall designate staff to act as liaison between the MCO and the Department. The Monitor shall be responsible for:

a. Receiving and responding to inquiries and requests made by the MCO, under the contract, in an expeditious manner.

b. Meeting with the MCO's representatives on a periodic or as-needed basis and resolving issues which arise.

c. Coordinating requests and activities from the MCO to ensure that Department staff with appropriate expertise in clinical, financial data, and marketing/enrollment matters is involved in MCO initiatives and quality improvement goals.

d. Making best efforts to resolve any issues identified either by the MCO or the Department that may arise that are applicable to the contract.

e. Monitoring compliance with the terms of this contract to include
    i. reviewing the performance of the MCO in relation to the performance standards outlined in this contract, in the application submitted in response to the contract.
    ii. collecting and reviewing standard hard copy and electronic reports and related documentation, including encounter data, which the MCO is required, under the terms of this contract, to submit to the Department or otherwise maintain;
    iii. conducting MCO, network provider, and subcontractor site visits; and
    iv. reviewing MCO policies and procedures and other internal documents.

    During the monitoring activities, the Department may assess the MCO's compliance with any requirements set forth in this contract and in the documents referenced herein.

5.2.2 MCO review of audit findings

The Department shall provide the results of any audit findings to the MCO for review. The Department may seek clarification of the results of any audit findings from the MCO or its duly authorized representative for the purpose of facilitating the MCO's understanding of how the audit was conducted and/or how the audit findings were derived. Any such request for clarification shall be in writing from the MCO to the Department. If the MCO disagrees with the audit findings, the MCO may signify its disagreement by submitting a claim in writing to the Department.

5.2.3 Readiness review and annual monitoring

The Department or its duly authorized representative may conduct a readiness review that will include a minimum of one site visit for each MCO that enters into a contract with the Department. This review may be conducted prior to enrollment of any recipients in the MCO and prior to the renewal of the contract and shall commence within 90 calendar days prior to the program implementation start date of February 1, 2009. The purpose of the review is to provide the Department with assurances that the MCO is able and prepared to perform all administrative functions and to provide high-quality services to enrolled recipients.

Specifically, the review will document the status of the MCO with respect to meeting program standards set forth in this contract, as well as any goals established by the MCO. The readiness review activities will be conducted by a multidisciplinary team appointed by the Department. The scope of the readiness review will include, but not be limited to, review and/or verification of: network provider composition and access; staffing; content of provider contracts; financial solvency; and information systems performance and interfacing capabilities. The readiness review may assess the MCO's ability to meet any requirements set forth in this contract and the documents referenced herein.

Recipients may not be enrolled in an MCO until the Department has determined that the MCO is capable of meeting these standards. A MCO's failure to pass the readiness review within ninety (90) calendar days of the execution of this contract may result in termination of the contract.

The Department will provide the MCO with a summary of the findings as well as areas requiring remedial action.

5.3 Eligibility and Enrollment

5.3.1 Determination of Medicaid eligibility and VALTC program enrollment

The Department shall have sole authority and responsibility for determining the eligibility of an individual for Medicaid funded services. The Department shall have sole responsibility for determining enrollment into the VALTC program, into the MCO's plan and for excluding individuals from participation, including those individuals meeting criteria as listed in Section 5.3.2. The MCO shall accept automatic assignment for any VALTC eligible enrollee. The MCO shall promptly notify the Department upon learning that an enrollee meets one or more of these exclusion criteria. Disenrollment from managed care by DMAS shall be in accordance with 42 CFR 438.56(b)(2)&(3). There shall be no retroactive enrollment into managed care. The Department makes no guarantees or representations to the MCO regarding the number of eligible Members who will ultimately be enrolled into the MCO or the length of time any such enrolling members remain enrolled with the MCO.

In conducting any enrollment-related activities permitted by this contract or otherwise approved by the Department, the MCO shall assure that enrollee enrollment is without regard to health status, physical or mental condition or handicap, age, sex, national origin, race, or creed. Individuals shall be enrolled in the order that the enrollees apply, up to the limits (if any) specified in this contract. The MCO shall notify the enrollee of his or her enrollment in the MCO's plan through a letter submitted simultaneously with the enrollee handbook, member ID card and provider directory.

The MCO shall be responsible for keeping its network of providers informed of the enrollment status of each enrollee. The MCO shall be able to report and ensure enrollment to network providers through electronic means.

5.3.2 Medicaid eligible individuals excluded from participation

The MCO shall cover all VALTC Medicaid eligible individuals, with the exception of individuals excluded from the program, and as defined in 12VAC30-121-40. The Department shall exclude individuals who meet at least one of the exclusion criteria listed below.

a. Individuals in the pilot areas under age 21, including dual eligibles and those enrolled in EDCD Waiver services, remain excluded from VALTC at this time.

   Note: The only exception to the under age 21 rule is for babies born to a VALTC-enrolled participant who will be covered by the VALTC-MCO for the birth month plus two months (a total of 3 months maximum), or until transitioned to a Medallion II MCO (if applicable), or whichever occurs first.

b. Individuals who are inpatients in State mental hospitals including but not limited to those listed below:
   i. Western State Hospital,
   ii. Southwestern VA Mental Health Institution,
   iii. Eastern State Hospital,
   iv. HW Davis Medical Center,
   v. Southern Virginia Mental Health Institution,
   vi. Western State HM&S,
   vii. Northern Virginia Mental Health Institution,
   viii. The Commonwealth Center for Children and Adolescents,
   ix. Central State Hospital,
   x. Southwestern State HM&S,
   xi. Catawba Hospital, and
   xii. Piedmont Geriatric Hospital

c. Individuals who are institutionalized (State Hospitals; ICF/MR facilities; Residential Treatment Facilities; long stay hospitals; existing nursing facility participants) at the implementation of the VALTC program.

d. Individuals who are placed on spend-down.

e. Individuals who are participating in the family planning waiver, or in federal waiver programs for home-and-community-based Medicaid coverage (excluding EDCD).

f. Individuals who are participating in foster care or subsidized adoption programs.

g. Newly eligible individuals who are in the third trimester of pregnancy and who request exclusion within a department-specified timeframe of the effective date of their MCO enrollment. Exclusion may be granted only if the member's obstetrical provider (physician or hospital) does not participate with the enrollee's assigned MCO. Exclusion requests made during the third trimester may be made by the recipient, MCO, or provider. DMAS shall determine if the request meets the criteria for exclusion. Following the end of the pregnancy, these individuals shall be required to enroll to the extent they remain eligible for Medicaid and the VALTC program.

h. Individuals, other than students, who permanently live outside their area of residence for greater than 60 consecutive days except those individuals placed there for medically necessary services funded by the MCO.

i. Individuals who are enrolled in, or enter a Medicaid-approved Hospice program.

j. Individuals with other comprehensive group or individual health insurance coverage, other than full benefit Medicare, insurance provided to military dependents, and any other insurance purchased through the Health Insurance Premium Payment Program (HIPP).

k. Individuals hospitalized at the scheduled time of initial enrollment. The exclusion shall remain effective until the first day of the month following discharge.

l. Individuals who request exclusion during assignment to an MCO, or within a time set by DMAS from the effective date of their MCO enrollment, who have been diagnosed with a terminal condition and who have a life expectancy of six months or less. The client's physician must certify the life expectancy.

m. Individuals who have an eligibility period that is less than three months.

n. Individuals who are enrolled in the Commonwealth's Title XXI SCHIP program.

o. Individuals who have an eligibility period that is only retroactive.

p. Individuals enrolled in the Virginia Birth-Related Neurological Injury Compensation Program established pursuant to Chapter 50 (§38.2-5000 et seq.) of Title 38.2 of the Code of Virginia.

q. Individuals enrolled in the Children's Mental Health Waiver.

r. Individuals enrolled in the Money Follows the Person (MFP) Project.

s. Individuals enrolled in the Technology Dependent, Mental Retardation, Individual and Family Developmental Disability, Alzheimer's, HIV/AIDS, and Day Support 1915(c) Waivers.

t. Individuals outside of the pilot areas will be excluded from the VALTC program at this time.

u. Individuals enrolled in a PACE program.

Individuals enrolled with a VALTC MCO that subsequently meet one or more of these criteria during MCO enrollment shall be excluded as appropriate by DMAS. Individuals excluded from mandatory managed care enrollment shall receive Medicaid services under the current fee-for-service system. When enrollees no longer meet the criteria for exclusion, they shall be required to enroll in the appropriate managed care program.

The Department shall, upon new State or Federal regulations or Department policy, exclude other individuals as appropriate.

5.3.3 Enrollment process and workflows

To receive managed long-term care benefits under the VALTC program, a Medicaid recipient must be aged 21 and over and be a member of the following targeted groups, as outlined in Section 5.1 of this contract:

- Elderly or Disabled with Consumer Direction (EDCD) waiver;
- Full benefit dual eligibles; or
- Full benefit dual eligibles receiving EDCD services.

Individuals residing in a nursing facility or other institutional placement will not be enrolled in VALTC.

After an individual has been determined eligible for the VALTC program, the Department shall initiate the enrollment process based upon the recipient's eligibility category. All participants in the VALTC program must select from two or more MCOs in the pilot localities, and must utilize the provider network within their selected plan. The process to select a MCO (and the providers within their networks) is described below and in Appendix A.

5.3.3.1 Enrollment of newly eligible EDCD recipients

i. The Pre-Admission Screening Team (PAS) shall complete the level-of-care determination.

ii. The local Department of Social Services shall determine the applicant's financial eligibility for Medicaid and the EDCD waiver.

iii. If the applicant meets the required level-of-care, the PAS shall offer the applicant the choice of a nursing facility placement, participation in the PACE program, or participation in the EDCD waiver. If the applicant selects the EDCD waiver, the PAS shall provide information to the applicant that includes a VALTC fact sheet and a MCO comparison chart. The VALTC fact sheet will include information about the basics of managed care and VALTC, and the populations mandatorily enrolled and those excluded from enrolling. The MCO comparison chart will include the health plans available in the area in which the individual lives, information on the plans, enhanced services offered, and contact information for the enrollment broker.

iv. Once financial eligibility is determined by DSS, DSS enters the applicant in VAMMIS and sends the patient pay amount, if applicable, to the Department.

v. Concurrently, the level-of-care information shall be forwarded to the Department by the PAS.

vi. Within seven (7) calendar days of DSS eligibility determination, DMAS shall enroll the recipient into the EDCD waiver and transfer the information to the enrollment broker who shall have the responsibility of attempting to telephonically contact the recipient for enrollment in the health plan of their choice and completion of the Health Status Assessment.

vii. Those recipients who do not actively select a health plan shall be automatically assigned to a health plan within three (3) calendar days of receipt of the participant's information by the enrollment broker via an algorithm set by the Department. The algorithm will attempt to match participants to a MCO that has a recently accessed provider in its network.

viii. Enrollment into the health plan will be effective weekly at 12:00 a.m. on the first Wednesday following enrollment by the enrollment broker.

ix. DMAS shall send the MCO Enrollment Report for these designated recipients via FTP on a weekly basis (at close of business each Friday) with all pertinent enrollee information including level-of-care information, transition report, and patient pay amounts, if applicable. The transition report will be available in electronic format and will contain at a minimum (Appendix B): enrollee name, Medicaid number, aid category, date of birth, sex, indication of capitation region or locality, claims data, patient pay amount and UAI data. The Weekly Report will contain only the newly enrolled EDCD recipients. The enrollment broker shall post the Health Status Assessments to a bulletin board weekly, by close of business Friday, for the MCOs to retrieve.

x. Upon receipt of enrollment information from the Department, the MCO shall send a member handbook and identification card to the enrollee within five (5) business days of the MCO's receipt of the weekly enrollment report as indicated in Section 5.4 of this contract.

5.3.3.2 Enrollment of existing EDCD recipients

Individuals living in the designated region who are in the EDCD waiver at the time of VALTC program implementation shall be enrolled as follows:

i. In mid-December and mid-January the VALTC system will identify existing EDCD participants in the catchment area for February 1, 2009, and March 1, 2009, (respectively) effective dates.

ii. The pre-assignment algorithm will look for ALTC Phase I participation or identify the most recent provider who matches a MCOs network. Comparison charts and a welcome letter urging participants to contact the enrollment broker will be sent to participants. Recipients enrolled in a Medicare SNP or Medicare Advantage Program under one of the MCO options available will be encouraged to maintain that same MCO for their VALTC selection, in order to provide consistency.

iii. Once the participant informs the enrollment broker of his or her MCO selection or maintains the pre-assigned MCO, DMAS will send the selected MCO the 834, transition report, and patient pay amount.

iv. Enrollment becomes effective on the first day of the month following the enrollment cycle. The MCO honors authorized services and conducts a transition of care plan (face to face or recipient's choice of location) within 90 calendar days of enrollment or at annual level of care (LOC) review, which ever comes first.

5.3.3.3 Enrollment of dual eligibles (non-EDCD waiver recipients)

Individuals living in the designated region who are current or newly enrolled dual eligibles shall follow a monthly enrollment cycle and be enrolled as follows:

i. The VALTC monthly system run will identify new dual eligible participants in the VALTC region. This also applies to the initial transition of dual eligibles in the VALTC program upon program launch.

ii. The VALTC pre-assignment cycle will send the participant a MCO comparison chart and a welcome letter explaining VALTC and urging participants to contact the enrollment broker to select a plan.

iii. The Department will not match the dual eligible participant to the VALTC MCO's plan's MA-PDP or SNP.

iv. After the participant selects their plan with the enrollment broker or maintains the pre-assigned MCO, the Department will send the selected MCO the 834 and transition report (if available).

5.3.4 Enrollment effective time

All enrollments, except for newly eligible EDCD recipients as described in Section 5.3.3.1.vii, are effective 12:00 A.M. on the first day of the first month in which they appear on the enrollment report, except for newborns, whose coverage begins at birth.

All disenrollments are effective 11:59 P. M. on the last day of enrollment. If the disenrollment is the result of a plan change, it is effective the last day of the month. If the disenrollment is the result of any exclusion, it may be effective any day during the month.

5.3.5 Role of enrollment broker

The Department and its enrollment broker shall be responsible for conducting all MCO enrollment activities for VALTC managed care eligible individuals. The State's enrollment broker shall continue to facilitate enrollment services for the VALTC program as the program expands statewide.

The enrollment broker does not handle eligibility determination related activities. Their primary function is to assist Medicaid enrollees in the selection of a managed care provider, upon initial enrollment, during the annual open enrollment period, and at other times as specified by DMAS and responding to managed care related questions, inquiries, and complaints.

The enrollment broker also provides the following services:

a. Assistance to beneficiaries, via incoming and outbound calls, in the decision process of choosing an MCO.

b. Specific information about each health plan such as the plan's network of providers including physicians, hospitals, home health agencies, long-term care providers, etc.

c. Transfer of specific information to DMAS and MCOs.

5.3.6 Enrollment notification

Except as noted in Section 5.3.3.1, Medicaid MCO recipients served under the VALTC program receive letters indicating that they may select one of the MCOs available in their area. These letters will indicate a pre-assigned MCO in which the recipient will be enrolled if he/she does not make a selection. The initial pre-assignment process will account for prior relationships established if and when the recipient was enrolled in another Medicaid program, e.g. EDCD waiver. This assignment method is designed to ensure the continuity of care already established between the provider and the recipient. Recipients have approximately thirty (30) days prior to the effective date of their enrollment in which to call the enrollment broker to confirm or change their selection.

5.3.7 Enrollment cap

The state reserves the right to cap enrollment of any MCO as indicated in Section 7.4 of this contract.

5.3.8 Care outside of enrollment effective dates

Except where required by the Department or by applicable Federal or State law, rule or regulation, DMAS shall not reimburse the MCO for health care provided prior to the effective date of the enrollee's enrollment with the MCO.

5.3.9 Enrollment of newborns

Any newborn enrollee whose mother is a VALTC Medicaid enrollee enrolled in the MCO's plan on his or her date of birth shall be deemed an enrollee of that MCO's plan for up to three calendar months (birth month plus 2 months). Newborn enrollees incorrectly enrolled under another family member's identification number remain the liability of the MCO with no exceptions. When incorrect enrollment of the newborn enrollee is discovered and later corrected, claims that were reimbursed incorrectly will be voided, and the provider will be notified to bill the enrollee's MCO. These claims may not be denied by the enrollee's MCO for any reason during the newborn coverage period (the birth month plus two

additional months). The newborn's continued enrollment with the MCO is not contingent upon the mother's enrollment. Additionally, if this contract is terminated in whole or in part by the MCO, (i.e., the MCO where the newborn's Mother is enrolled on the newborn's date of birth), the MCO shall continue newborn coverage until the newborn receives a Medicaid number (and is disenrolled in the Department's MMIS at the next monthly cycle), or for the birth month plus 2 month timeframe, whichever is earlier.

The MCO shall have written policies and procedures governing the identification of newborns by their network providers. The MCO must make a good faith effort to complete and send the DMAS Form 213-MCO for Newborns (Appendix C) details required field information) to the local DSS. The MCO is responsible for advising the Department monthly of all newborns that do not receive an identification number within 60 days. The MCO is responsible for advising the mother/guardian of the newborn that Medicaid ensures continuous eligibility for the child up to 12 months following birth; however, to receive coverage, the local DSS office must be notified of the birth. Additionally, the MCO is responsible for advising the Department quarterly of all live birth outcomes via electronic report using the format reflected in Appendix D.

Infants born to mothers enrolled with Medicaid who receive a Medicaid identification number prior to the end of the third month will be enrolled in the Medallion II Medicaid managed care program, if eligible, through the pre-assignment process.

The Department shall reimburse the MCO appropriate capitation for a newborn of an enrolled recipient during the birth month plus two additional months. Payments for newborns not reflected on the MCO's payment report (820) shall be handled via the reconciliation process. The charges for newborns to mothers enrolled with the MCO are the responsibility of the MCO in all cases. The MCO may not deny payment to a provider as a result of DSS newborn enrollment errors or because payment is not reflected on the MCO's 820 payment report, or for timely filing due as a result of enrollment errors.

5.3.10 Enrollment reports/information exchange

The Department shall post MCO Enrollment Reports to an FTP server with inbound and outbound directories using an electronic data interchange (EDI) transaction set to the MCO. The date of availability of this information to the bulletin board is dependent upon the Department's eligibility cut-off date and monthly enrollment update cycle. The Department shall provide the MCO with a copy of the MMIS eligibility cut-off schedule at least annually. The MCO Enrollment Reports shall provide the MCO with ongoing information about its enrollees and disenrollees and shall be used as the basis for the monthly capitation payments. The MCO Enrollment Reports will be generated in the following sequence (except for recipients described in Section 5.3.31):

a. The EDI benefit enrollment and maintenance transactions (834) (Mid-Month and End of the Month Enrollment Report) will list all of the MCO's enrollees for the enrollment month who are known on the report generation date, including any new EDCD recipients added during the month and previously reported on the weekly reports. The Mid-Month Enrollment Report will be provided to the MCO approximately the twentieth (20th) day of the month prior to recipient enrollment. The End of the Month Enrollment Report will be provided to the MCO approximately the second (2nd) day of the month following recipient enrollment. In addition to the Mid-Month and End of the Month Enrollment Reports, an EDI benefit enrollment transactions (834) (Weekly New Waiver Enrollment Report) will also be provided to the MCO. The Weekly New Waiver Enrollment Report will list only the MCO's new waiver enrollees who became eligible since the last Enrollment Report as of the report generation date. The Weekly New Waiver Enrollment Report will be provided to the MCO on Friday of each week. Should any of these enrollment reports be delayed in its delivery to the MCO, the applicable timeframes for identification card issuance and PCP notification shall be extended by

one (1) business day for each day the enrollment report is delayed. The Department and the MCO shall reconcile each enrollment report as expeditiously as is feasible. The report will be available in electronic format and will contain at a minimum: enrollee name, Medicaid number, aid category, date of birth, sex, and locality. The report will be sorted by enrollment status (new enrollee, continuing enrollee, or those individuals that have been disenrolled).

b. The MCO shall receive a single 834 that contains all applicable recipient enrollment information. However, each MCO will be required to obtain and use separate service center IDs to submit their encounter data for VALTC and 'traditional' Medicaid. The 834 is being modified to provide multiple benefit loops which will allow the MCO to identify the VALTC recipient's 'risk category'. VALTC MCO enrollment, EDCD waiver enrollment, and nursing home (when applicable) will be reported in the benefits segment of the 834 for the VALTC recipients. MCOs will also need to look at the TPL segment on the 834 to determine if a recipient is dual eligible.

c. The Payment Report will list all of the MCO's enrollees for the enrollment month who are known on the report generation date. The Payment Report will be provided to the MCO on or before the tenth (10th) day of the month of client enrollment. The report will be available in electronic format and will contain at a minimum: enrollee name, Medicaid number, aid category, date of birth, sex, and locality, amount of monthly capitation payment or retraction for the enrollee, and the month which the payment or retraction reflects. The report will be sorted by enrollment status (new enrollee, continuing enrollee, or those individuals that have been disenrolled).

d. The MCO shall work with the Department to ensure that the enrollment databases of the Department and the MCO are reconciled. The Department may audit the MCO's Medicaid enrollment database.

e. Retroactive adjustments to enrollment and payment files shall be forwarded to the MCO as soon as possible upon receipt of updated/corrected information. The MCO shall cover retroactive adjustments to enrollment without regard to timeliness of the adjustment.

The MCO shall assure correct payment to providers as a result of enrollment update/correction. The Department shall assure correct payment to the MCO for any retroactive enrollment adjustments.

5.3.11 Enrollment period

Following their initial enrollment into an MCO, enrollees shall be restricted to that VALTC MCO until the next open enrollment period, unless disenrolled under one of the conditions described in Section 5.3.13 and pursuant with Section 1932 (a)(4)(A) of Title XIX.

For the initial ninety (90) calendar days following the effective date of enrollment, the enrollee will be permitted to disenroll from one MCO to another MCO without cause. This ninety (90) day time frame during which a client may disenroll without cause applies to the client's initial period of enrollment and to any subsequent enrollment periods when they enroll in a new MCO.

If the enrollee does not disenroll during the ninety (90) day period, he/she may not disenroll without cause for the remainder of the enrollment period.

In addition, within sixty (60) calendar days prior to the open enrollment date, the Department will inform the enrollee of the opportunity to remain with the current MCO or change to another MCO without cause. Those enrollees who do not choose a new MCO within sixty (60) days prior to the end of the open enrollment period shall remain in his or her current MCO.

The enrollee may disenroll from any VALTC MCO to another at any time, for cause, as defined by the Department in Section 5.3.13.

5.3.12 Open enrollment

Recipients will be notified of their ability to change plans during an annual open enrollment period at least sixty (60) days before the end of their enrollment period. Enrollment selections will be effective no later than the first day of the second month following the month in which the enrollee makes the request for the change in plans.

5.3.13 Disenrollment

a. Voluntary disenrollment
All enrollees shall have the right to disenroll from the MCO's plan to another health plan, pursuant to 42CFR438.56, as amended, or §1903 (m)(2)A of the Social Security Act, as amended, unless otherwise limited by an approved CMS waiver of applicable requirements. During the first ninety (90) calendar days following the effective date of enrollment, an enrollee may disenroll for any reason. A voluntary disenrollment shall be effective no later than the first day of the second month after the month in which the enrollee requests disenrollment.

Consistent with §1932(A)(4) of the Social Security Act, as amended (42 U.S.C. §1396u-2), the Department must permit an enrollee to disenroll at any time for cause. The request may be submitted orally or in writing to the Department and cite the reason(s) why he or she wishes to disenroll. VALTC recipients may request disenrollment to change to another health plan, for the following reasons:

i. A recipient desires to seek services from a federally qualified health center (FQHC) that is not under contract with the recipient's current MCO;
ii. Performance or nonperformance of service to the recipient by an MCO or one or more of its providers which is deemed by the department's external quality review organization to be below the generally accepted community practice of health care;
iii. Lack of access to a PCP or necessary specialty services covered under the state plan, or lack of access to providers experienced in dealing with the enrollee's health care needs;
iv. Recipient's currently assigned MCO does not include home-and-community-based care provider(s) through which they have received consistent services;
v. Currently assigned MCO is unable to meet recipient's long-term care needs;
vi. A client has a combination of complex medical factors that, in the sole discretion of DMAS, should be better served under another MCO under contract with DMAS;
vii. The enrollee moves out of the MCO's VALTC service area;
viii. The MCO does not, because of moral or religious objections, cover the service the enrollee seeks;
ix. The enrollee needs related services to be performed at the same time; not all related services are available within the network, and the enrollee's primary care provider or another provider determines that receiving the services separately would subject the enrollee to unnecessary risk; or
x. Other reasons as determined by DMAS which will be considered on a case-by-case basis.
xi. Recipients who are enrolled in or change to a Medicare Advantage or Special Needs Plan may request a change in Medicaid MCO health plans for good cause in order to be enrolled in the same entity for both programs. Although Medicare Advantage recipients may change Medicare plans monthly, good cause requests honored for this reason under the VALTC program will be limited to one change per calendar year (after initial 90 day period).

The Department will review the request in accordance with cause for disenrollment criteria defined in 42CFR438.56(d)(2) and 12VAC30-121-40. The Department will respond to "cause" requests, in writing, within 15 business days of the Department's receipt of the request. In accordance with 42CFR438.56(e)(2), if the Department fails to make a determination by the first day of the second month following the month in which the enrollee files the request, the disenrollment request shall be considered approved and effective on the date of approval.

Upon disenrollment the MCO is encouraged to send each enrollee a disenrollment letter with the effective date of disenrollment. Upon receipt of an inquiry, the MCO should provide instructions for the disenrolled enrollee to contact the Department of Social Services (DSS) with any questions regarding Medicaid eligibility. With respect to the disenrollment of newborns, the MCO should inform mother/parent/guardian that in order to continue the newborn's Medicaid eligibility, the mother/parent/guardian must go to DSS to obtain a Medicaid identification number for the newborn.

MCOs may only request disenrollment of enrollees during the last trimester of pregnancy for new enrollees, or when an enrollee has been consistently non-compliant and has exhausted all avenues for assistance, supported by documentation by the MCO. These cases will be reviewed by DMAS on an individual basis.

b. Loss of eligibility due to status change

The enrollee will lose eligibility upon occurrence of any of the following events:

i. Death of the enrollee;
ii. Cessation of Medicaid eligibility;
iii. Individuals that meet at least one of the exclusion criteria listed in Section 5.3.2 of this contract. The Department shall determine if the individual meets the criteria for exclusion;
iv. Transfer to a Medicaid eligibility category not included in this contract; or
v. Certain changes made within the Medicaid Management Information System by eligibility case workers at the Department of Social Services.

The Department will determine the need for status change disenrollment based on input and supporting documentation from the MCO and/or other source(s).

The MCO shall not be liable for the payment of any services covered under this contract rendered to an enrollee after the effective date of the enrollee's exclusion or loss of eligibility, except for specially manufactured DME that was prior-authorized by the MCO. However, in cases where disenrollment is anticipated, secondary to the recipient's participation in a home-and-community-based care waiver other than the EDCD waiver, hospice, or other exclusionary program, the MCO is responsible for the authorization and provision of all services covered under this contract until notified of the disenrollment by the Department.

In certain instances an individual may be excluded from participation effective with retroactive dates of coverage. In these cases the recipient's enrollment with the MCO is ended retroactively. The MCO is not liable for services rendered outside of the recipient's dates of enrollment with the MCO. Providers may submit claims to the Department for services rendered during this retroactive period. Reimbursement by the Department for services rendered during this retroactive period is contingent upon the recipient's meeting eligibility and coverage criteria requirements.

The MCO shall be entitled to a capitation payment for the enrollee based on the recoupment/reconciliation procedures in Section 6.2. The MCO shall not be entitled to payment

during any month subsequent to status change determination. Capitation payments already paid by the Department for months beyond the month in which the event occurred shall be repaid to the Department in accordance with the provisions of this contract.

c. MCO transfer of information upon enrollee disenrollment or exclusion

In accordance with 42 C.F.R. § 434.53, as amended, the MCO will assist the Department in collecting data regarding reasons for enrollment and disenrollment in the MCO's managed care plan.

The Department will share with the MCO data that its agents have regarding reasons for enrollment and disenrollment at least on a monthly basis. When an enrollee for whom services have been authorized but not provided as of the effective date of exclusion or disenrollment is excluded or disenrolled from the MCO's plan and/or from VALTC, the MCO shall provide to the Department or the relevant PCP the history for that enrollee upon request. This prior authorization history shall be provided to the Department or the relevant PCP within five (5) business days of request.

5.3.14 Opt-Out provisions

All enrolled VALTC EDCD Waiver participants whose medical and long-term care (waiver) services were covered by FFS at the implementation of this program will be pre-assigned with a VALTC MCO; however, in addition to "good cause" criteria which allows them to change MCOs, or disenrollment through exemption criteria as set forth in regulations, this group has additional "opt-out" provisions under certain conditions and circumstances as determined by DMAS.

Exemption or "opt-out" requests may be made if enrollment in the VALTC program would detrimentally impact the health, safety or welfare of the participant. These requests must come from the participant, legal guardian, and/or responsible party. Each request to "opt-out" of the VALTC program will be evaluated by a DMAS committee on a case-by-case basis to ensure appropriate, accessible, and quality care for the individual. The DMAS committee will be comprised of staff from the long-term care and managed care units, and the DMAS Medical Director, as appropriate.

Approval to "opt-out" of program participation returns the participant to FFS through which all medical and waiver services are covered by DMAS.

5.3.15 Automatic re-enrollment

Enrollees who have been previously enrolled with the MCO who regain eligibility for VALTC enrollment within sixty (60) calendar days of the effective date of exclusion or disenrollment and who do not select another MCO will be reassigned to the previous MCO, as appropriate, (provided sufficient enrollee slots are available under this contract) and without going through the selection or pre-assignment process.

5.3.16 PCP notification of enrollee panel

The MCO must have in place policies and procedures that are acceptable to the Department for notifying PCPs of their panel composition within five (5) business days of the date on which the MCO receives the weekly or monthly enrollment report from the Department.

5.3.17 Enrollment verification

The MCO must have in place policies and procedures to ensure that in-and out-of-network providers can verify enrollment in the MCO's plan prior to treating a patient for non-emergency services. The MCO

must provide within five (5) business days of the date on which the MCO receives the weekly or monthly enrollment report from the Department, the ability to verify enrollment by telephone or by another timely mechanism.

5.3.18 Choice of health professionals

The MCO must have written policies and procedures for assigning each of its enrollees, excluding dual eligibles, to a PCP. Any changes or modifications to these policies and procedures must be submitted by the MCO to the Department at least thirty (30) calendar days prior to implementation and must be approved by the Department. These policies and procedures shall include the features listed below:

a. Providers Qualifying as PCPs
   The following types of specialty providers may perform as PCPs:
   i. Pediatricians;
   ii. Geriatricians;
   iii. Family and General Practitioners;
   iv. Internists;
   v. Obstetrician/Gynecologists;
   vi. Specialists who perform primary care functions, e.g., surgeons, clinics, including but not limited to Federally Qualified Health Centers, Rural Health Clinics, Health Departments, and other similar community clinics; or
   vii. Other providers approved by the Department.

b. Specialists as PCPs
   Enrollees with disabling conditions, chronic illnesses, or with special health care needs may request that their PCP be a specialist. The MCO shall have in place procedures for ensuring access to needed services for these enrollees or shall grant these PCP requests, as is reasonably feasible and in accordance with MCO's credentialing policies and procedures.

c. Enrollee Choice of PCP
   The MCO shall offer each enrollee covered under this contract the opportunity to choose a PCP affiliated with the MCO to the extent that open panel slots are available.

d. Default Assignment of PCP
   If the enrollee does not request an available PCP prior to the twenty-fifth (25^{th}) day of the month prior to the enrollment effective date, then the MCO may assign the new enrollee to a PCP within its network, taking into consideration such known factors as current provider relationships (as indicated on the transition of care report), language needs (to the extent they are known), age and sex, enrollment of family members (e.g., siblings), and area of residence. The MCO then must notify the enrollee in writing, on or before the first effective date of enrollment with the MCO, of his or her PCP's name, location, and office telephone number.

   In the case of newly enrolled EDCD recipients, as outlined in Section 5.3.3.1, the MCO may assign within two (2) business days the new enrollee to a PCP within its network, taking into consideration such known factors as current provider relationships (as indicated on the transition of care report), language needs (to the extent they are known), age and sex, enrollment of family members (e.g., siblings), and area of residence. The MCO then must notify the enrollee in writing, within five (5) business days of the effective date of enrollment with the MCO, of his or her PCP's name, location, and office telephone number.

e. Timing of PCP Assignment
The enrollee must have an assigned PCP from the date of enrollment with the plan.

f. Change of PCP
The MCO must allow enrollees to select or be assigned to a new PCP when requested by the enrollee, when the MCO has terminated a PCP, or when a PCP change is ordered as a part of the resolution to a formal grievance proceeding. When an enrollee changes his or her PCP, the MCO must make the enrollee's medical records or copies thereof available to the new PCP within ten (10) business days from receipt of request.

5.3.19 Delay of enrollment due to hospitalization

Enrollees who are inpatients in hospitals, other than those listed in Section 5.3.2 of this contract, at the scheduled time of enrollment are restricted from enrollment with the MCO until the first day of the month following discharge, as set forth in 12VAC30-121-40. This does not pertain to newborns who are enrolled as described in Section 5.3.9.

An enrollee who is discharged from one hospital and admitted to another hospital within twenty-four (24) hours (facility to facility transfers) for continued treatment of the same diagnosis shall not be considered discharged under this section.

5.4 Enrollee Information

5.4.1 Enrollee rights

In accordance with 42 CFR § 438.100, the MCO shall have written policies and procedures regarding enrollee rights and shall ensure compliance of its staff and affiliated providers with any applicable Federal and State laws that pertain to enrollee rights. Policies and procedures shall include compliance with: Title VI of the Civil Rights Act of 1964 as implemented at 45 CFR Part 80; the Age Discrimination Act of 1975 as implemented by regulations at 45 CFR Part 91; the Rehabilitation Act of 1973; and Titles II and III of the Americans with Disabilities Act; and other laws regarding privacy and confidentiality. At a minimum such enrollee rights include the right to:

i. Receive information in accordance with 42 CFR § 438.10 as described in Sections 4.5.2 through 4.5.4 of this contract.
ii. Be treated with respect and with due consideration for his or her dignity and privacy.
iii. Receive information on available treatment options and alternatives presented in a manner appropriate to the enrollee's condition and ability to understand.
iv. Participate in decisions regarding his or her health care, including the right to refuse treatment.
v. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in other Federal regulations on the use of restraints and seclusion.
vi. Request and receive a copy of his or her medical records and request that they be amended or corrected, as specified in 45 CFR §§ 164.524 and 164.526.
vii. Free exercise of rights and the exercise of those rights does not adversely affect the way the MCO and its providers treat the enrollee.
viii. Be furnished health care services in accordance with 42 CFR §§ 438.206 through 438.210 as described in this contract.

5.4.2 Enrollee information packet

The MCO shall mail each enrollee (within 5 business days of receipt of the enrollment file) an information packet indicating the enrollee's effective date of enrollment. The MCO shall utilize at least first class or priority mail delivery services as the medium for providing the member identification cards. The Department must receive a copy of this packet on an annual basis for review. At a minimum, the enrollee information packet shall include:

a. An introduction letter.

b. A VALTC identification card that includes the enrollee's Medicaid ID number, Medicare ID number if applicable, and the enrollee's co-payment responsibility, if applicable.

c. A description of the service area and Provider Directory listing names, locations, telephone numbers, and non-English languages spoken by contracted providers in the enrollee's service area, including identification of providers that are not accepting new patients. This includes at minimum information on primary care physicians, long-term care providers, specialists, and hospitals. Additionally, this directory must identify any restrictions that could impact the enrollee's freedom of choice among network providers. [42 CFR 438.10.f.6]

d. A description of (1) the new member materials issued by the MCO and what action the member is to take if they have not yet received those materials; (2) how to access MCO-provided transportation services; (3) what to do if they want to change their primary care physician; (4) the population groups that are not required to enroll in an MCO and what action to take if they believe they meet this criteria and do not wish to be enrolled in that MCO; and (5) to contact the MCO if they or someone in their assistance group has a health care condition which the MCO should be aware of in order to most appropriately manage/transition their care.

e. An Enrollee Handbook.
If an individual is re-enrolled within 60 days of disenrollment, the MCO is only required to send the recipient a new identification card. However, the complete Enrollee Information Packet must be supplied upon request by the recipient.

5.4.3 VALTC Enrollee handbook

The MCO shall submit a copy of the VALTC Enrollee Handbook to the Department for approval thirty (30) calendar days prior to printing. The Department will respond within thirty (30) calendar days of the date of the Department's receipt of the request. The MCO must update the Enrollee Handbook annually, addressing changes in policies through submission of a cover letter, identifying sections that have changed and/or a red-lined contract showing before and after language. The red-lined document may be submitted on paper or electronically. Such changes must be approved by the Department prior to dissemination to enrollees and shall be submitted to the Department at least thirty (30) calendar days prior to planned use. The Department will respond to changes within thirty (30) calendar days of the date of the Department's receipt of the request. If the Department has not responded to the MCO within thirty (30) days from receipt of the Enrollee Handbook, the MCO may proceed with its printing schedule. Any changes to content subsequent to printing shall be corrected through an addendum or subsequent printing mutually agreed upon between the MCO and the Department.

The MCO's VALTC Enrollee Handbook shall reflect a copy of the enrollee rights, as referenced in this contract, as provided at open enrollment.

The Enrollee Handbook must be mailed to each enrollee (and potential enrollee if requested) within 5 business days after the MCO receives notice of the enrollee's enrollment. Once a year the Department will notify managed care enrollees of their right to request and obtain this information from the MCO. The Handbook must include at a minimum the following information:

a. Table of Contents

b. Enrollee Eligibility
    i. Effective date and term of coverage.
    ii. Terms and conditions under which coverage may be terminated.

c. Choosing or Changing an MCO
    i. Procedures to be followed if the enrollee wishes to change MCOs.

d. Choosing or Changing a PCP
    i. Information about choosing and changing PCPs and a description of the role of Primary Care Providers.

e. Making Appointments and Accessing Care
    i. Appointment-making procedures and appointment access standards.
    ii. A description of how to access all services including specialty care and authorization requirements.
    iii. The role of the PCP and the MCO in directing care.

f. Enrollee Services
    i. A description of all available VALTC covered services including long-term care services, preventive services, and an explanation of any service limitations, referral and prior authorization requirements. The description shall include the procedures for obtaining benefits, including family planning services, from out-of-network providers.
    ii. A description of who is eligible for long term care services.
    iii. A description of the enhanced services that the MCO offers.
    iv. Instructions on how to contact Member or Customer Services of the MCO and a description of the functions of Member or Customer Services.
    v. Notification that each enrollee is entitled to a copy of his or her medical records and instructions on how to request those records from the MCO.
    vi. Instructions on how to utilize the after-hours Medical Advice and Customer Services Departments of the MCO.
    vii. A description of the MCO's confidentiality policies.
    viii. Advice on how enrolled individuals may acquire services that are covered under Medicaid but not under the VALTC contract. The Department shall provide a list of these services and how they may be accessed.
    ix. A description of consumer directed services.

g. Emergency Care
    i. The telephone number to be used by enrollees for assistance in obtaining emergency care.
    ii. The definition of an emergency using the "prudent layperson" standard, a description of what to do in an emergency, instruction for obtaining advice on getting care in an emergency, and the fact that prior authorization is not required for emergency services. Enrollees are to be instructed to use the emergency medical services available or to activate emergency services by dialing 911.

iii. A description of how to obtain emergency transportation and other medically necessary transportation.
iv. How to appropriately use emergency services and facilities.
v. Information indicating that emergency services are available out-of-network without any financial penalty to the enrollee.
vi. Definition of and information regarding coverage of post-stabilization services in accordance with 42 CFR § 422.113(c).
vii. The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post-stabilization services covered under this contract.

h. Enrollee Identification Cards
   i. A description of the information printed on the identification card, including the Medicaid ID number.
   ii. A description of when and how to use the identification card.

i. Enrollee Responsibilities
   i. A description of procedures to follow if:
      a. The enrollee's family size changes;
      b. The enrollee's address changes;
      c. The enrollee moves out of the MCO's service area, (where the enrollee must notify the DSS office regarding change of address and must notify the MCO for assistance to receive care outside of the MCO's service area until the member is disenrolled);
      d. He or she obtains or has health coverage under another policy or there are changes to that coverage.
   ii. Actions the enrollee can make towards improving his or her own health, enrollee responsibilities, appropriate and inappropriate behavior, and any other information deemed essential by the MCO.
   iii. Information about advance directives such as living wills or durable power of attorney, in accordance with 42 CFR 489.100, 42 CFR 438.6 (i) (3) and (4) and 12 VAC 30-10-130.
   iv. Notification of any pharmacy co-payment the enrollee will be required to pay. Additionally, notification that there are no cost sharing responsibilities for Medicaid covered services other than for pharmacy services.
   v. Information regarding the enrollee's repayment of capitation premium payments if enrollment is discontinued due to failure to report truthful or accurate information when applying for Medicaid.
   vi. Information regarding payment of the patient pay toward the cost of long-term care services, if applicable.

j. MCO Responsibilities
   i. Notification to the enrollee that if he or she has another health insurance policy to notify their local Department of Social Services caseworker. Additionally, inform the enrollee that the MCO will coordinate the payment of claims between the insurance plans.

k. Grievances and Appeals [42 CFR §438.10(f)]
   i. A description of the grievance and appeals procedures including, but not limited to, the issues that may be resolved through the grievance or appeals processes; the fact that enrollees have the right to appeal directly to the Department for a State fair hearing and providing the Department's address for the appeals; the process for obtaining necessary forms; and procedures and applicable timeframes to register a grievance or appeal with the MCO or the Department as described in Section 5.35 of this contract.

ii. The availability of assistance in the filing process.
iii. The toll-free numbers that the enrollee can use to file a grievance or an appeal by telephone.
iv. A description of the continuation of benefits process as required by 42CFR438.420 and information describing how the enrollee may request continuation of benefits, as well as information on how the enrollee may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the enrollee.
v. The telephone numbers to register complaints regarding providers (Health Professionals, 1-800-533-1560) and MCOs (Managed Care Helpline, 800-643-2273).

l. Interpretation and Translation Services
i. Information on how to access oral interpretation services, free of charge, for any non-English language spoken. [42CFR438.10(c)(5)(i)]
ii. A multilingual notice that describes translation services that are available and provides instructions explaining how enrollees can access those translation services. [42CFR438.10(c)(5)(i)]. As the size of the MCO's non-English speaking enrollee population attains the threshold specified in Section 5.5 for translation of the enrollee handbook into a language other than English, the MCO shall be responsible for such translation. Some of this information may be included as inserts in or addenda to the Evidence of Coverage. As the enrollee handbook is translated into other languages, the MCO shall provide a language appropriate copy to all such non-English speaking enrollees.
iii. Information on how to access the handbook in an alternative format for special needs individuals including, for example, individual's with visual impairments. [42CFR438.10(d)(2)]

m. Program or Site Changes
i. When there are changes to covered services, benefits, or the process that the enrollee should use to access benefits, (i.e., different than as explained in the member handbook), the MCO shall ensure that affected enrollees are notified of such changes at least fourteen (14) calendar days prior to their implementation. For example: changes to who they call for transportation services, changes to covered and/or enhanced benefits, as described in the Contractor's member handbook, etc.

n. Additional Information that is available upon request, including the following:
i. Information on the structure and operation of the MCO.
ii. Physician incentive plans as set forth in 42 CFR 438.6(h).

5.4.4 Enrollee identification card

The MCO shall provide each enrollee an identification card that is recognizable and acceptable to the MCO's network providers. The MCO's identification card must also serve as sufficient evidence of coverage for non-participating providers. The MCO's identification card shall include, at a minimum, the name of the enrollee, the Medicaid identification number, enrollee co-payment responsibility (as applicable), the name and address of the MCO, the name of the enrollee's primary care provider, a telephone number to be used to access after-hours non-emergency care, instructions on what to do in an emergency, and a MCO identification number, if applicable. The MCO must submit and receive approval of the identification card from the Department prior to production of the cards.

The MCO shall provide each enrollee with an identification card within five (5) business days of receipt of the weekly or monthly enrollment report. MCO must mail all enrollee identification cards, utilizing at

least first class or priority mail delivery services, in envelopes marked with the phrase "Return Services Requested."

The MCO shall provide the Department on a monthly basis the date and the number of identification cards mailed to new members enrolled each month. Additionally, the MCO shall submit a monthly report of returned I.D. cards. The report must identify all returned cards, with the enrollee's Medicaid identification number, first/last name, incorrect address, and correct address, if available.

5.5 Communication Standards

The MCO shall participate in the Department's efforts to promote the delivery of services in a culturally competent manner to all enrollees including those with limited English proficiency and diverse cultural and ethnic backgrounds.

The MCO shall ensure that documents for its membership, such as the enrollee handbook, are comprehensive yet written to comply with readability requirements. For the purposes of this contract, no program information document shall be used unless it achieves a Flesch total readability score of forty (40) or better (at or below a 12th grade educational level) and is set at a 12-point font. The document must set forth the Flesch score and certify compliance with this standard. (These requirements shall not apply to language that is mandated by Federal or State laws, regulations or agencies.) Additionally, the MCO shall ensure that written membership material is available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited. [42CFR438.10(d)(1)(ii)]

The MCO shall make available enrollee handbooks and other enrollee information in languages other than English when five percent (5%) of the MCO's enrolled population is non-English speaking and speaks a common language. The populations will be assessed by VALTC regions and will only affect handbooks and other information distributed in the affected region.

The MCO shall institute a mechanism for all enrollees who do not speak English to communicate effectively with their PCPs and with MCO staff and subcontractors.

Oral interpretation services must be available to ensure effective communication regarding treatment, medical history, or health education. [42CFR438.10(c)(4)] Trained professionals shall be used when needed where technical, medical, or treatment information is to be discussed with the enrollee, a family enrollee or a friend. If five hundred (500) or more of its enrollees are non-English speaking and speak a common language, the MCO must include, if feasible, in its network at least two (2) medically trained professionals who speak that language. In addition, the MCO must provide TTY/TDD services for individuals with hearing impairments.

All enrollment, disenrollment and educational documents and materials made available to VALTC enrollees by the MCO must be submitted to the Department for its review annually, unless specified elsewhere in this contract.

5.6 Marketing and Promotional Materials and Activities

For the purposes of this contract, "Marketing Materials and Services" activities as defined shall apply to enrollees who may or may not be currently enrolled with the MCO. All Contractors are encouraged to utilize subcontractors for marketing purposes; however, Contractors will be held responsible by the Department for the marketing activities and actions of subcontractors who market on their behalf.

Marketing and promotional activities (including provider promotional activities) must comply with all relevant Federal and State laws, including, when applicable, the anti-kickback statute, civil monetary penalty prohibiting inducements to beneficiaries. An organization may be subject to sanctions if it offers or gives something of value to a recipient that the organization knows or should know is likely to influence the beneficiary's section of a particular provider, practitioner, or supplier of any item or service for which payment may be made, in whole or in part, by Medicaid. Additionally, organizations are prohibited from offering rebates or other cash inducements of any sort to beneficiaries.

5.6.1 Marketing services

The MCO shall:

a. Offer its plan to enrollees and provide to those interested in enrolling adequate, written descriptions of the MCO's rules, procedures, benefits, fees and other charges, services, and other information necessary for enrollees to make an informed decision about enrollment.

b. Submit to the Department for prior written approval a complete marketing plan annually.

c. Submit all new and/or revised marketing and informational materials to the Department before their planned distribution. The Department will approve, deny, or ask for modifications to the materials within thirty (30) days of the date of receipt by the Department. (42CFR 438.104)

d. Distribute marketing materials to the MCO's eligible population or the entire population on a city or countywide basis. The Department must approve a request for a smaller distribution area. The MCO may distribute marketing materials to prospective recipients where the recipient is enrolled with the MCO's Medicare product, within all applicable Medicare Advantage Marketing Guidelines, as set forth in Chapter 3 of CMS's Medicare Managed Care Manual, as well as all applicable statutes and regulations including and without limitation Section 1851 (h) of the Social Security Act and 42 CFR Sections 422.80, 422.111, and 423.50.

e. Coordinate and submit to the Department all of its schedules, plans, and informational materials for community education, networking and outreach programs. The schedule shall be submitted to the Department at least two (2) weeks prior to any event.

f. Assure that all marketing and informational materials shall set forth the Flesch readability scores of 40 or higher (at or below the 12^{th} grade reading level) and set at a 12-point font, and certify compliance therewith.

g. Be subject to a fine or other sanctions if it conducts any marketing activity that is not approved in writing by the Department. (42 CFR 438.700)

5.6.2 Allowable MCO marketing activities

The MCO may engage in the following promotional activities during preassignment or open enrollment:

a. Notify the general public of the VALTC managed care program in an appropriate manner through appropriate media, throughout its enrollment area.

b. Distribution through the Department or its agents and posting of written promotional materials pre-approved by the Department.

c. Pre-approved mail campaigns through the Department or its agents to regions of potential enrollees and pre-approved informational materials for television, radio, and newspaper dissemination.

d. Fulfillment of potential enrollee requests to the MCO for general information, brochures, and/or provider directories that will be mailed to the enrollee.

e. Marketing and/or networking at community sites or other approved locations.

f. Hosting or participating in health awareness events, community events, and health fairs pre-approved by the Department. Representatives from the Department, the enrollment broker and/or local health departments may be present. The MCO must make available informational material that includes the enrollment comparison chart. The MCO is allowed to collect names and telephone numbers for marketing purposes; however, no Medicaid ID numbers may be collected at the event. DMAS will supply copies of benefit charts upon proper notification.

g. Health screenings may be offered by the MCO at community events, health awareness events, and in wellness vans. The MCO shall ensure that every enrollee receiving a screening is instructed to contact his or her PCP if medical follow-up is indicated and that the enrollee receives a printed summary of the assessment information to take to his or her PCP. The MCO is encouraged to contact the enrollee's PCP directly to ensure that the screening information is communicated.

h. Offers of free non-cash promotional items and "give-aways" that do not exceed a total combined nominal value of $15 to any prospective enrollee or family for marketing purposes. Such items must be offered to all eligibles for marketing purposes whether or not the enrollee chooses to enroll in the MCO's plan. The MCO is encouraged to use items that promote good health behavior, e.g., toothbrushes or immunization schedules.

i. The MCO is allowed to offer non-cash incentives to their enrolled members for the purposes of retaining membership, and/or rewarding for compliance in immunizations, prenatal visits, participating in disease management programs, etc. These incentives shall not be limited in amount as stated in item "h." above. This incentive shall not be extended to any individual not yet enrolled in the MCO's plan. The MCO must submit all incentive award packages to DMAS for approval prior to implementation. Non-cash incentives may include gift cards.

5.6.3 Prohibited marketing and outreach activities

The following are prohibited marketing and outreach activities targeting prospective enrollees under this contract:

a. Engaging in any informational or marketing activities which could mislead, confuse, or defraud enrollees or misrepresent the Department. (42CFR 438.104)

b. Directly or indirectly, conducting door-to-door, telephonic, or other "cold call" marketing of enrollment at residences and provider sites. (42CFR 438.104)

c. Direct mailing. All mailings must be processed through the Department or its agent except Medicaid or Medicare to members of the MCO.

d. Making home visits for marketing or enrollment activities except when requested by the recipient.

e. Offering financial incentive, reward, gift, or opportunity to eligible enrollees as an inducement to enroll in the MCO's plan other than to offer the health care benefits from the MCO pursuant to their contract or as permitted above.

f. Continuous, periodic marketing activities to the same prospective enrollee, e.g., monthly or quarterly give-aways, as an inducement to enroll.

g. Using the DMAS eligibility database to identify and market its plan to prospective enrollees or any other violation of confidentiality involving sharing or selling enrollee lists or lists of eligibles with any other person or organization for any purpose other than the performance of the MCO's obligations under this contract.

h. Engaging in marketing activities which target prospective enrollees on the basis of health status or future need for health care services, or which otherwise may discriminate against individuals eligible for health care services.

i. Contacting enrollees who disenroll from the plan by choice after the effective disenrollment date except as required by this contract or as part of a Department approved survey to determine reasons for disenrollment.

j. Engaging in marketing activities which offer potential enrollees a rebate or a discount in conjunction with the sale of any private insurance, as a means of influencing enrollment or as an inducement for giving the MCO the names of prospective enrollees. (42CFR 438.104)

k. No enrollment related activities may be conducted at any marketing, community, or other event unless such activity is conducted under the direct on-site supervision of the Department or its enrollment broker.

l. No educational or enrollment related activities may be conducted at Department of Social Services offices unless authorized in advance by the Department of Medical Assistance Services.

m. No assertion or statement (whether written or oral) that the MCO is endorsed by the Centers for Medicare and Medicaid Services (CMS); Federal or State government; or similar entity. (42CFR 438.104)

n. No assertion or statement that the recipient must enroll with the MCO in order to keep from losing benefits. (42CFR 438.104)

5.6.4 Medicare marketing

The MCO agrees to follow the Medicare Advantage Marketing Guidelines as set forth in Chapter 3 of CMS's Medicare Managed Care Manual, as well as all applicable statutes and regulations including and without limitation Section 1851 (h) of the Social Security Act and 42 CFR Sections 422.80, 422.111, and 423.50 when marketing to individuals entitled to enroll in Medicare Advantage.

5.7 Contract Amendments and Rates

Contract amendments and rates are negotiated and released annually on a fiscal year (July 1 – June 30) basis. Contract amendments and rates for fiscal year 2009 will be released the first week of June 2008.

5.8 VALTC Covered Services

The MCO should reference Appendix E for a complete listing of all VALTC covered acute care services. The MCO shall promptly provide, arrange, purchase, or otherwise make available all services, with the exception of the carved-out services, required under the contract resulting from this contract and as further defined under the State Plan for Medical Assistance (State Plan) as amended, 1915(b) and 1915(c) waivers, written Department policies (including, but not limited to, contracts, statements, provider manuals, Medicaid memorandums, instructions, or memoranda of understanding) and all applicable State and Federal regulations, guidelines, transmittals, and procedures. MCO's response to this contract shall provide a description of the understanding of each service and how services shall be provided. It is not acceptable to state that services shall be provided.

MCOs may establish a prior authorization process and criteria and prior authorize services as they deem necessary. In no case shall the MCO establish more restrictive benefit limits for medically necessary services than those established by Medicaid as defined in the State Plan and other documents identified above. The MCO shall manage service utilization through utilization review, prior authorization, and care coordination but not through the establishment of benefit limits for medically necessary services that are more restrictive than those established by Medicaid. In accordance with 42 CFR §438.210, the MCO shall not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition.

Coverage decisions that depend upon prior authorization and/or concurrent review to determine medical necessity must be rendered in accordance with the requirements described in Section 5.34 of this contract.

The MCO shall assume responsibility for all covered medical conditions of each enrollee as of the effective date of coverage under the contract, regardless of the date on which the condition arose. The MCO shall cover all pre-existing conditions. This responsibility for all covered medical conditions shall not apply in the case of persons temporarily excluded from enrollment due to hospitalization.

5.9 State Laws and Regulations Governing the Provision of Medical Services

The MCO shall be required to comply with all State laws and regulations, including, but not limited to: (1) the Code of Virginia Title 38.2, Chapter 43, as amended; (2) Rules Governing Health Maintenance Organizations, Virginia Administrative Code, Title 14, as amended, Chapter 5-210; (3) Virginia Administrative Code, 12VAC30-121-10 through 12VAC30-121-100; and (4) Code of Virginia, Title 32.1, Chapter 9.

5.10 Modification in Scope of Covered Services

The Department, at its sole discretion, may reduce, increase, or otherwise modify covered services required by this contract. If appropriate, the Department shall modify the capitation payment in an amount deemed, in the sole opinion of the Department, to be appropriate. The Department shall notify the MCO in advance of any modification to the capitation payment. Should the MCO be unable or unwilling to provide the increased, reduced, or modified covered services at the capitation rate provided by the Department, the contract may be terminated by the MCO following the termination procedures specified in Section 11.8.

5.11 Enhanced Services

Enhanced services are those services offered by the MCO to enrollees in excess of VALTC covered services. Nothing in this contract shall preclude the MCO from providing additional health care health

improvement services or other services not specified in this contract, including but not limited to chiropractic care, dental care, step down nursing care, and psychiatric care provided in a freestanding psychiatric hospital, as long as these services are available, as needed or desired, to enrollees. No increased reimbursement shall be made for additional services provided by the MCO under this contract. The MCO must inform the Department at least thirty (30) calendar days prior to implementing any new enhanced services and prior to implementing revisions to existing enhanced services. The MCO must report annually the enhanced services it offers. Enhanced services for step-down care or adult psychiatric care provided in a free-standing psychiatric hospital may not be used to substitute for state plan covered services.

If an enhanced service is provided through the MA-PDP or SNP, the MCO shall indicate the services on comparison charts and should explicitly note such on all marketing, educational, and enrollment materials.

Enhanced services offered by the MCO are listed in the Department's VALTC Managed Care Program comparison charts. Comparison charts are revised once annually. Any changes to enhanced services occurring after the annual comparison chart publication cannot be incorporated until the next annual revision. Revisions to enhanced services should be made only at open enrollment. However, the MCO may revise enhanced services at any date, if the MCO accepts the cost of revising and printing comparison charts. The MCO must be able to provide to the Department, upon request, data summarizing the utilization of enhanced services provided to enrollees during the contract year for rate setting purposes.

The MCO shall not obtain enrollment through the offer of any compensation, reward, or benefit to the enrollee except for additional health-related services which have been included in the response to the contract or have since been added by the MCO and approved by the Department.

Provision of an enhanced service that is a service qualifying an individual for exclusion from VALTC shall not be the sole basis for exclusion from VALTC; in order to be excluded from VALTC, individuals must meet the Department's criteria for receiving that service.

5.12 Medical Necessity

The MCO shall cover all medically necessary services, as defined in this contract, and in accordance with 42 C.F.R. § 440.230, State Plan for Medical Assistance (State Plan), as amended and as further defined by written Department policies (including contracts, statements, provider manuals, Medicaid memorandums, instructions, or memoranda of understanding) and all applicable State and Federal regulations, guidelines, transmittals, and procedures. The actual provision of any service is subject to the professional judgment of the MCO's providers as to the medical necessity of the service, except in situations in which the MCO must provide services ordered by the Department pursuant to an appeal from the MCO's grievance process or an appeal directly to the Department by an enrollee or for emergency services as defined in this contract. Decisions to provide authorized medical services required by this contract shall be based solely on medical necessity and appropriateness. Disputes between the MCO and enrollees about medical necessity may be appealed to the Department by the enrollee or the enrollee's representative.

Long-term care services shall be provided to support a participant in his or her ability to perform activities of daily living (ADLs) and instrumental activities of daily living (IADLs). The MCO shall cover appropriate long-term care services based on needs identified through a functional assessment such as the Uniform Assessment Instrument and subsequent level of care evaluations.

5.13 Moral or Religious Objections

In accordance with 42 CFR §438.102 the MCO shall not be required to provide, reimburse for, or provide coverage of a counseling or referral service if the MCO objects to the service on moral or religious grounds in accordance with all of the following guidelines:

Information Requirements – The MCO must furnish information about the services it does not cover:

a. To the Department:
    i. With the initiation of the contract and each subsequent renewal.
    ii. Upon adoption of such policy in the event that the MCO adopts the policy during the term of the contract.

b. To potential enrollees, before and during enrollment.

c. To enrollees, within 30 days before the effective date of this policy.

5.14 Out-of-State Services

The MCO is not responsible for services obtained outside the state unless they are emergency services or post-stabilization services. The MCO shall cover services outside the state if services are needed because of a medical emergency, because the enrollee's health would be endangered if he were required to travel back to the state, if the Department determines the needed services are more readily available in another state, or if it is a general practice for enrollees in a particular locality to use medical resources in another state. If an enrollee goes out of state for non-emergency services (including urgent services) that are not authorized by the MCO in advance of the service, other than as described above, the MCO is not responsible.

An exception applies to enrollees who use consumer-directed personal or respite services. The MCO shall cover consumer-directed personal or respite services if an enrollee needs a consumer-directed attendant to accompany the enrollee out of state for no more than thirty (30) days per occurrence. The attendant must be enrolled as an employee of the enrollee who is authorized to receive consumer-directed personal or respite services.

5.15 Coverage of Prior Authorized Services

The MCO shall assume responsibility for all managed care covered services authorized by either the Department or a previous MCO, which are rendered after the enrollment effective date, in the absence of a written contract otherwise. The MCO shall allow their new enrollees who are transitioning from Medicaid fee-for-service or another MCO to receive services from out-of-network providers if the enrollee contacts the MCO in advance of the service date and the enrollee has an appointment(s) within the initial month of enrollment with a specialty physician(s) that was scheduled prior to the effective date of membership. For on-going services, such as long-term care, home health, outpatient mental health, and outpatient rehabilitation therapies, etc., the MCO shall continue prior authorized services without interruption until the MCO completes its utilization review process to determine medical necessity of continued services or to transition services to a network provider. The out-of-network provider for transitional services shall be reimbursed at the Medicaid fee-for-service rate.

The Department shall assume responsibility for all covered services authorized by the enrollee's previous MCO which are rendered after the effective date of disenrollment to the fee-for-service system, if the enrollee otherwise remains eligible for the service(s). If services have been pre-authorized using a

provider who is not a Medicaid provider, DMAS may elect to re-authorize (but not deny) those services using a Medicaid provider.

If the prior authorized service is an inpatient stay, the financial responsibility shall be allocated as follows:

i. For per diem provider contracts, reimbursement will be shared between the MCO and either the Department or the new MCO. In the absence of a written contract otherwise, the MCO and the Department or the new MCO shall each pay for the period during which the enrollee is enrolled with the entity. This also applies to newborns hospitalized at the time of enrollment.

ii. For DRG provider contracts, in accordance with Section 6 the MCO is responsible to pay for the full inpatient hospitalization with outliers (admission to discharge), including for any member actively enrolled in the MCO on the date of admission, regardless of the member's disenrollment from the MCO during the course of the inpatient hospitalization.

As recipients transition between a fee-for-service and MCOs, the MCO must be able to receive weekly and monthly information from and provide monthly information to DMAS or their subcontractors on services previously authorized. The MCO must honor the DMAS FFS or other DMAS contracted MCO issued prior authorizations for services and must have system capabilities to accept service authorizations from DMAS FFS and other DMAS MCOs.

5.16 Out-of-Network Services

The MCO shall cover and pay for all authorized care that it has pre-authorized and provided out of its established network. Out-of-network claims must be paid in accordance with the Medicaid fee schedule in place at the time the service was rendered or at another fee negotiated between the MCO and the provider of services.

The MCO shall cover and pay for emergency and family planning services rendered to an enrollee by a non-participating provider or facility, as set forth elsewhere in this contract.

The MCO shall cover, pay for, and coordinate care, rendered to enrollees by out-of-network providers when the enrollee is given emergency treatment by such providers outside of the service area, subject to the conditions set forth elsewhere in this contract.

The MCO shall cover and pay for services furnished in facilities or by practitioners outside the MCO's network if the needed medical services or necessary supplementary resources are not available in the MCO's network.

To ensure against adverse disenrollment, the MCO must provide coverage out-of-network for any of the following circumstances:

a. When a service or type of provider is not available within the MCO's network or where the MCO cannot provide the needed specialist within the distance standard of more than 30 miles in urban areas or more than 60 miles in rural areas.

b. For up to 30 days to transition the client to an in-network provider when a provider that is not part of the MCO's network has an existing relationship with the beneficiary, is the beneficiary's main source of care, and has not accepted an offer to participate in the MCO's network.

c. When the providers that are available in the MCO's network do not, because of moral or religious objections, furnish the service the client seeks.

5.17 VALTC Carved-Out and Excluded Services

The MCO is not required to cover VALTC carved-out and excluded services, as listed in Appendix E which are defined through Medicaid memos, Federal and State laws and regulations, and Medicaid policy manuals.

Enrollees who receive services, as listed in Appendix E that meet the criteria for exclusion from the VALTC program shall be excluded from VALTC participation. Once the MCO determines that an enrollee is receiving these services and notifies the Department, the Department will begin the process to exclude the enrollee. Until the Department has excluded the enrollee, the MCO is responsible for covering VALTC services for that enrollee.

5.18 VALTC Covered Medicare Services

Dual eligibles are recipients who are eligible for coverage from Medicare (Medicare Part A, Part B, or both) *and* Virginia Medicaid. Only "full benefit" duals are included in the VALTC program. The VALTC program will not include individuals who are required to "spend down" income in order to meet Medicaid eligibility requirements nor will it include "non" full benefit dual eligibles (these are individuals for whom DMAS only pays a limited amount each month toward their cost of care [e.g., deductibles or coinsurance only]) such as:

- Qualified Medicare Beneficiaries (QMBs),
- Special Low Income Medicare Beneficiaries (SLMBs),
- Qualified Disabled Working Individuals (QDWIs), or
- Qualified Individuals (QI).

Coverage for dual eligibles must be provided in accordance with all applicable Federal and State code and regulations. Applicable State regulations include, but are not limited to:

a. 12VAC30-10-310. Coordination of Medicaid with Medicare and other insurance: Premiums.

b. 12VAC30-10-320. Coordination of Medicaid with Medicare and other insurance: deductibles/coinsurance.

c. 12VAC30-80-170. Payment of Medicare Part A and Part B Deductible/Coinsurance.

Medicare services may be provided to dual eligible recipients on a fee-for-service basis, through a Medicare Advantage (MA) Plan, or through a Special Needs Plan (SNP). MCO shall have the ability to encourage dual eligibles that are enrolled in the Medicaid portion of the health plan to also enroll in the plan's MA-PDP or SNP for the Medicare portion of their benefits. Dual eligibles may receive Medicaid coverage for the following:

a. Not included in VALTC capitation rate:
    i. Medicare monthly premiums for Part A, Part B, or both (DMAS will pay Medicare Part A and/or Part B premiums directly to CMS. Premiums will not be included in the capitation rate).

b. Included in VALTC capitation rate:
    i. Coinsurance, copayment, and deductible for Medicare-allowed services (i.e., "crossover claims").
    ii. Medicaid-covered services, even those that are not allowed by Medicare.

All participating dual eligibles will be entitled to the same Medicaid benefit package. The dual eligible benefit package will not differ among participants based on Medicaid aid category.

Except for a few instances, Virginia Medicaid is the payer of last resort for any Medicaid-covered service. Therefore, the provider is required to make a reasonable effort to exhaust all other health insurance sources before submitting claims to VALTC managed care organization. Providers are required to prepare complete and accurate documentation of efforts to bill Medicare to substantiate Medicare disclaimer codes used on any claim. State law limits Medicaid reimbursement for coinsurance and deductibles of Medicare Part A and/or Part B services provided to dual eligible recipients.

5.18.1 Medicaid reimbursement for crossover claims

A Medicare Crossover claim is a Medicare-allowed claim for a dual eligible recipient for payment of coinsurance, deductible, and copayment. Virginia, under §1902(n) of the Social Security Act, uses the Medicaid rate as payment in full for a service. Total payment for a Medicare Part A or Part B service (i.e., any amount paid by other health insurance sources, any Medicaid copayment amounts due from the recipient, and any amount paid by a VALTC MCO) may not exceed the Medicaid-allowed amount. Therefore, Medicaid reimbursement for coinsurance and/or deductible of a Medicare Part A or Part B service is the **lesser** of the following:

- *Medicaid*-allowed amount less any amount paid by other health insurance sources (including Medicare) and any Medicaid patient pay or copayment amounts due from the recipient.
- The sum of the coinsurance and deductible amounts as a result of the Medicare payment.

This rate is lower than the Medicare rate, therefore, in some instances, the VALTC MCO will actually make no payment, since the amount the provider receives from Medicare exceeds the allowed state payment rate.

Refer to the following table for examples of how the limitations are applied.

Medicaid Reimbursement for Coinsurance or Deductible of Medicare Part A and/or B Services			
Explanation	**Example**		
	1	**2**	**3**
Provider's billed amount	$120	$120	$120
Medicare payment	$80	$80	$80
Medicaid-allowed amount (e.g., maximum allowable fee, rate-per-visit)	$90	$110	$75
Coinsurance and/or deductible from Medicare	$20	$20	$20
Medicaid payment	$10	$20	$0

5.18.2 Crossover claims process

A crossover claim is a claim for a dual eligible's payment of coinsurance, deductible, and copayment. Crossover claims will be the responsibility of VALTC MCOs.

VALTC MCOs will receive crossover claims through three scenarios:

a. A participant enrolled in the VALTC Medicaid MCO and Medicare fee-for-service;

b. A participant enrolled in the VALTC Medicaid MCO and in a different MCO's Medicare Advantage plan or SNP; or

c. A participant enrolled in the VALTC Medicaid MCO's Medicare Advantage plan or SNP.

Scenario A: Participant enrolled in the VALTC Medicaid MCO and Medicare fee-for-service.

In this scenario, providers submit their claims through their standard Medicare claims process. GHI processes the Medicare liability and pays the provider for the Medicare portion of the claim. GHI then sends the crossover remittance to First Health Services (the DMAS fiscal agent). First Health Services pays the provider for any VALTC Medicaid carved out service. First Health Services then sends the remittance to the applicable VALTC MCO for payment of any remaining Medicaid liability (e.g. crossover payment). The VALTC MCO processes the remittance and pays the provider any further amount owed.

Scenario B: Participant enrolled in the VALTC Medicaid MCO and in a different MCO's Medicare Advantage plan or SNP.

In this scenario, providers submit their claims to the participant's Medicare Advantage Plan or SNP and that plan pays the provider for the Medicare portion of the claim. Next, the provider submits the remittance to the VALTC MCO. The VALTC MCO pays the remaining Medicaid liability of the claim. If liability remains for a carved out service, the provider resubmits the claim to First Health Services for payment of the carved out service.

Scenario C: Participant enrolled in the VALTC Medicaid MCO's Medicare Advantage plan or SNP.

In this scenario, providers submit claims to the participant's Medicare Advantage Plan or SNP and the VALTC MCO pays the provider for both the Medicare and Medicaid liability. If liability remains for a carved out service, the provider resubmits the claim to First Health Services for payment of the carved out service.

The contracted MCOs shall work with the Department to clarify and streamline the crossover claims process.

Refer to workflows in Appendix F.

5.18.3 Balance billing

VALTC participating dual eligibles are protected from liability for Part A and B charges even when the amounts the provider receives from Medicare and Medicaid are less than the Medicare rate or less than the provider's customary charges. CMS Guidance Document, February 27, 2008; Subsections\Att 1 to ARA Memo Balance Billing 022708.pdf; Subsections\Att 2 to ARA Memo Capitation 022708.pdf

5.18.4 Retroactive eligibility

If a recipient becomes retroactively eligible for Medicare, the provider is required to refund or adjust any Medicaid payments for the retroactive period. The provider is required to bill Medicare for the services

and follow a VALTC MCO's procedure for submitting crossover claims. Claims found to be in conflict with this program requirement will be recouped.

5.18.5 Claims for services denied by Medicare

When Medicare denies payment for a service provided to a dual eligible that is covered by Medicaid, the provider may proceed as follows:

i. Submit a claim to the appropriate VALTC MCO, using the proper coordination of benefit code. A copy of Medicare remittance information should not be attached to the claim unless specific billing instruction indicates the requirement.

5.18.6 Claims that do not require Medicare billing

If a service is not covered by Medicare, providers should submit claims to the appropriate VALTC MCO without first submitting them to Medicare.

5.18.7 Pharmacy co-payments and deductibles

DMAS fee-for-service has provisions for pharmacy co-pays for Medicaid covered drugs ($1 generic, $3 brand). There are no deductibles for pharmacy services.

5.18.8 Covered drug classes

The MCO shall provide benefits for prescription drugs administered under Medicare Part A (typically payments made to hospitals and nursing facilities which cover drugs provided during a stay), Part B (typically injectables and infusible drugs that are not usually self–administered and are furnished an administered as part of a physician service) and Part D (typically prescription drugs) based on current coverage guidelines.

In addition, there are specific drug classes that, by law, are not covered under the Medicare Part D program but are covered by Medicaid. The MCO shall cover these medications within the currently established guidelines of the DMAS pharmacy benefit program. Coverage of these drugs will be in accordance with existing Medicaid policy as described in Chapter 50 of the Virginia Administrative Code (12 VAC 30-50; "Amount, Duration, and Scope of Medical/Remedial Services").

Those drug classes that Medicare does not cover, but that are covered by Medicaid for dual eligibles are as follows:

Table I: Non-Part D Drugs Covered by Medicaid:

i. Medications for weight loss (prior authorization required);
ii. Legend and non-legend medications for symptomatic relief of cough and colds;
iii. Prescription vitamins and mineral products (except prenatal vitamins and fluoride preparations);
iv. Over-the-counter medications (prescriptions are required);
v. Barbiturates; and
vi. Benzodiazepines.

Compound Drugs

The MCO shall cover compounded medications for Part D recipients, in cases where the active ingredients include only the drugs listed in Table I above and the compound is prior authorized.

5.19 VALTC Covered Nursing Facility Services

Individuals residing in a nursing facility or other institutional placement will not be enrolled in VALTC. Only individuals enrolled in VALTC ***prior*** to a nursing facility admission will maintain enrollment in VALTC for 60 days. If their nursing facility admission exceeds 60 days, the individual will be excluded from VALTC and participate in fee-for-service.

The MCO shall refer all members in need of nursing facility care to a local Pre-Admission Screening Team to be prescreened and complete the UAI prior to admission. This screening must be done regardless of the recipient's anticipated length of stay in the nursing facility setting.

Once a recipient is screened, authorized, and enters a nursing facility, the nursing facility shall follow normal admissions procedures, including submitting a Patient Intensity Rating Survey (PIRS) form DMAS within five (5) business days of the date of nursing facility admission. This information is used to enroll the recipient into the DMAS MMIS system.

A VALTC Medicaid beneficiary enrolled in MCO's health plan, who is referred by the health plan to a nursing facility and has received the pre-admission screening, shall remain a member of the health plan for a period of 60 days beginning with the date of admission to the nursing facility. If the beneficiary remains in the nursing facility upon completion of the 60-day period, the beneficiary shall be disenrolled from the health plan and shall begin receiving nursing facility services under the traditional fee-for-service (FFS) program. The MCO shall cover all medically necessary services until the recipient is disenrolled from the MCO.

Arrangements for nursing facility services between a managed care organization and a Medicaid-participating nursing facility during this 60-day period shall be based upon referral relationships. MCOs may contract with nursing facilities; however, DMAS shall not require contractual agreements between nursing facilities and managed care organizations. If a Medicaid beneficiary that is enrolled in a VALTC managed care plan enters a nursing facility under a Medicare Part A stay, the 60-day clock for continued managed care enrollment shall begin upon entry to the nursing facility.

While the VALTC MCO shall be responsible for the cost of nursing facility care during this 60-day period, payment for services shall be made directly from DMAS in a manner that is identical to payment made under the FFS program. From the perspective of the nursing facility, there shall be no distinction or modification to the existing processes for claims submission, claims processing and payment, cost reporting and cost settlement for services provided during the 60-day managed care coverage period. DMAS shall utilize an established methodology to adjust capitation payments made to MCOs for the cost of nursing facility services provided to plan beneficiaries during the 60-day period.

Payment to nursing facilities will be made by the Department based on prospective FFS per-diem rates. Nursing facility payments made by the Department will then be offset against the otherwise payable aggregate MCO capitation amount in the subsequent quarter. Nursing facility FFS per-diem rates are "cost settled" with the nursing facilities on an annual basis. The Department will not make any adjustment to the amount of nursing facility payment offset applied to the MCO's aggregate capitation regardless of subsequent cost settlements with the nursing facilities. The contracted health plans shall work with DMAS in the development of this methodology.

During the 60-day managed care coverage period, the VALTC MCO shall be responsible for non-nursing home services and shall work with the nursing home on discharge planning if appropriate. During this period, the MCO shall assess the probability that the individual may return to the community. The MCO shall make every effort to assist the participant in receiving care in the setting of his or her choice. If a

return to the community is unlikely, the MCO shall report this finding to DMAS at or around day 45 of the individual's nursing facility placement.

This provision outlined above shall apply only to individuals already receiving Medicaid benefits and enrolled in a VALTC managed care plan upon nursing facility admission. The existing processes for claims submission, claims processing and payment, cost reporting and cost settlement related to services provided to nursing facility residents with traditional FFS Medicaid coverage shall not change.

Services provided to individuals entering nursing facilities that are deemed Medicaid eligible and receive coverage subsequent to admission shall be subject to the payment provisions of the FFS program.

Nothing in this contract shall preclude the MCO from providing additional health care improvement services or other services not specified in this contract, including but not limited to step down nursing care as long as these services are available, as needed or desired, to enrollees. Should a managed care organization seek to utilize nursing facility services for plan beneficiaries that would not otherwise meet Medicaid nursing facility coverage criteria, these services would not be subject to the above provisions and would create the necessity for a contractual arrangement, including the establishment of payment rates and claims payment provisions, between the MCO and the nursing facility.

5.20 VALTC Covered Transportation Services

The MCO shall cover emergency and non-emergency transportation to ensure that enrollees have necessary access to and from providers of medical and long-term care services for emergency or non-emergency services. Per 12VAC30-50-530, these modes include, but shall not be limited to, non-emergency air travel, non-emergency ground ambulance, stretcher vans, wheelchair vans, common user bus (intra-city and inter-city), volunteer/registered drivers, and taxicabs. The MCO shall cover air travel for critical needs. The MCO shall cover travel expenses determined to be necessary to secure medical examinations and treatment as set forth in § CFR 440.170(a). The MCO shall cover transportation to all Medicaid covered services, even if those Medicaid covered services are reimbursed by an out-of-network payer or are carved-out services as defined in this contract. The MCO shall cover transportation to and from Medicaid covered community mental health and rehabilitation services. The Department allows the MCO to subcontract for all transportation services. The MCO shall cover travel expenses determined to be necessary to secure medical examinations and treatment as set forth in § CFR 440.170(a) including coverage of out-of-town and out-of-state transportation services for the family members/attendants of enrollees. The MCO shall assess, and provide if necessary, enrollees' needs for special transportation requirements, which may include but not be limited to, ambulance, stretcher van, curb to curb, door to door, or hand to hand services.

The MCO shall assure that provider contracts (through the MCO or the subcontractor) include the following language:

a. Requirements for drivers
   The MCO shall assure that all drivers of vehicles transporting recipients meet the following requirements:
   i. All drivers shall have a current valid driver's license from the Commonwealth of Virginia.
   ii. Drivers shall not have any prior convictions for sexual abuse, barrier crimes, or crimes of violence.
   iii. No driver or attendant shall use alcohol, narcotics, illegal drugs or prescription medications that impair ability to perform while on duty and no driver shall abuse alcohol

or drugs at any time. The transportation provider shall not use drivers who are known abusers of alcohol or known consumers of narcotics or drugs.

iv. All drivers and attendants shall wear and have visible a nametag that is easily readable and identifies the employee and the employer. The driver shall show the nametag to the recipient or a facility employee upon arrival for picking up the recipient.

v. Drivers or attendants must exit the vehicle to open and close vehicle doors when passengers enter or exit the vehicle. Drivers or attendants must provide an appropriate level of assistance to passengers when requested or when necessitated by the passenger's mobility status and personal condition. This includes curb-to-curb, door-to-door, and hand-to-hand assistance, as required.

vi. If a curbside pick-up is not being made, drivers shall identify themselves, show their identification and announce their presence at the entrance of the facility or residence at the specified pick-up location or to attending facility staff.

vii. Drivers shall assist passengers in the process of being seated and confirm that all seat belts are fastened properly.

viii. Drivers shall properly secure all wheelchairs and wheelchair passengers.

ix. Drivers shall provide necessary assistance, support, and oral directions to passengers. Such assistance shall include assistance with recipients of limited mobility, and movement and storage of mobility aids and wheelchairs.

b. Requirements for vehicles

i. All vehicles shall have functioning, clean and accessible seat belts for each passenger seat position. Each vehicle shall utilize child safety seats when transporting children under age eight.

ii. All vehicles shall have a functioning speedometer and odometer.

iii. All vehicles shall have the transportation provider's name, vehicle number (if applicable), and the MCO's phone number prominently displayed within the interior of each vehicle.

iv. Smoking is prohibited in all vehicles while transporting recipients. All vehicles shall post "no smoking" signs in all vehicle interiors, easily visible to the passengers.

v. All vehicles shall be equipped with a first aid kit.

vi. All vehicles must meet State, Federal, local, and manufacturer's safety and mechanical operating and maintenance standards for the vehicles.

vii. Vehicles shall comply with the American's with Disabilities Act (ADA) regulations.

5.21 VALTC Covered Long-Term Care Services

The MCO shall cover long-term care services as provided through the EDCD home-and community-based waiver. Services covered under the EDCD waiver include: adult day health care, assistive technology, environmental modifications, personal care, personal emergency response services, respite care, transition coordination, and transition services. The EDCD waiver also includes a unique feature known as "consumer-direction." Consumer-direction allows participants to serve as the employer for the individual who provides personal care and/or respite care for them. Consumer direction is optional for EDCD/VALTC participants, however, when available for a selected service, it must be offered to VALTC participants.

The State does not limit or restrict qualified participants access to waiver services. In accordance with 42 CFR §431.151, a participant may select among qualified providers in the MCO's provider network to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

5.21.1 Adult Day Health Care (ADHC) Services – Agency-Directed Only

Adult Day Health Care Services (ADHC) in Virginia may be offered to elderly individuals and individuals with physical disabilities who have been assessed to be at risk of institutionalization, meet the criteria for nursing facility care, and have been screened by a Pre-Admission Screening (PAS) Team for ADHC services and authorized. ADHC services are defined as long-term maintenance or supportive services which are necessary in order to enable the participant to remain at home rather than enter a nursing facility.

ADHC services are designed to prevent institutionalization by providing participants with health, maintenance, and rehabilitation services in a congregate daytime setting. The significant difference between ADHC and personal care is the congregate setting in which ADHC is rendered. The MCO shall enter into Participation Agreements with qualified adult day care centers which are licensed by the Virginia DSS.

The services offered by the ADHC Center must be designed to meet the needs of the individual participant. Thus, the range of services provided by the ADHC Center to each participant may vary to some degree. There must, however, be a minimum range of services available to every Medicaid ADHC participant: nursing services, rehabilitation services coordination, transportation, nutrition, social services, recreation, and socialization services.

Service criteria are described in detail in the EDCD regulations at 12VAC30-120-940 and the provider manual at http://websrvr.dmas.virginia.gov/manuals/edcd/EDCD_chapter_4.pdf

5.21.2 Assistive Technology (AT)

Assistive Technology is specialized medical equipment, supplies, devices, controls, and appliances not available under the Virginia State Plan for Medical Assistance, which enable individuals to increase their abilities to perform ADLs or to perceive, control, or communicate with the environment in which they live, or which are necessary to their proper functioning. Assistive Technology devices are expected to be portable.

a. The equipment and activities are:
    i. Specialized medical equipment, ancillary equipment, and supplies necessary for life support not available under the Virginia State Plan for Medical Assistance;
    ii. Durable or non-durable medical equipment (DME) and supplies not available under the Virginia State Plan for Medical Assistance;
    iii. Adaptive devices, appliances, and controls not available under the Virginia State Plan for Medical Assistance that enable an individual to be more independent in areas of Personal Care and ADLs; and
    iv. Equipment and devices not available under the Virginia State Plan for Medical Assistance, which enable an individual to communicate more effectively.

b. To qualify for assistive technology, the Department's current standards require that providers cannot be spouses or parents of the waiver individual. In addition, items are not approved for purposes of convenience for the caregiver or restraint of the individual.

    Under the current DMAS assistive technology program, equipment or supplies already covered by the Virginia State Plan for Medical Assistance may not be purchased under EDCD Waiver Assistive Technology. A copy of the Durable Medical Equipment and Supplies List is available from DMAS

and can be used to ascertain whether an item is covered through the Virginia State Plan for Medical Assistance before requesting it through the EDCD Waiver.

Under the current DMAS assistive technology program, each Assistive Technology item must be recommended and determined appropriate to meet the individual's needs by the following professionals, prior to approval:

Examples of Assistive Technology Devices (not a comprehensive list)	Professional Assessment Required
Organizational Devices	Occupational Therapist, Psychologist, or Psychiatrist
Computer/Software or Communication Device	Speech Language Pathologist or Occupational Therapist
Orthotics, such as braces	Physical Therapist or Physician
Writing Orthotics	Occupational Therapist or Speech Language Pathologist
Support Chairs	Physical Therapist or Occupational Therapist
Specialized Toilets	Occupational Therapist or Physical Therapist
Other Specialized Devices/Equipment	Physician, Speech Language Pathologist, Behavioral Consultant, Psychologist, Psychiatrist, Physical Therapist, or Occupational Therapist; depending on the device or equipment
Specially Designed Utensils for Eating	Occupational Therapist or Speech Language Pathologist
Weighted Blankets/Vests	Physical Therapist, Occupational Therapist, Psychologist, or Behavioral Consultant

A Rehabilitation Engineer may be utilized if (for example):

i. The Assistive Technology will be initiated in combination with Environmental Modifications involving systems which are not designed to go together; or
ii. An existing device must be modified or a specialized device must be designed and fabricated.

c. Under the current DMAS program, the service unit is the total cost of the item and any supplies, or hourly for Rehabilitation Engineering. The maximum Medicaid-funded expenditure is $5,000.00 on assistive technology per plan-of-care (POC) year. The cost for Assistive Technology cannot be carried over from one POC year to the next, and must be pre-authorized each POC year. The provider may not balance bill the participant.

d. Documentation requirements under the DMAS program are as follows:
   i. Supporting documentation, which includes the need for the service, the process to obtain this service (contacts with potential vendors or contractors, or both, of service, costs, etc.); and the time frame during which the service is to be provided. This includes separate notations of evaluation, design, labor, and materials. The supporting documentation must include the reason that a Rehabilitation Engineer or Certified Rehabilitation Specialist is needed, if one is to be involved. A Rehabilitation Engineer or Certified Rehabilitation Specialist may be involved if disability expertise is required that a General MCO will not have;
   ii. Written documentation regarding the process and results of ensuring that the item is not covered by the Virginia State Plan for Medical Assistance as Durable Medical Equipment and Supplies and that it is not available from a DME provider when purchased elsewhere;
   iii. Documentation of the date services are rendered and the amount of service needed;

iv. Any other relevant information regarding the device or modification;
v. Documentation by the designated individual or individual's representative of satisfactory completion of the service; and
vi. Instructions regarding any warranty, repairs, complaints, or servicing that may be needed.

Service criteria are described in detail in the propose regulations at 12VAC30-120-70
http://www.townhall.state.va.us/L/ViewXML.cfm?textid=1628

5.21.3 Agency-directed (AD) and consumer-directed (CD) models of service

Agency-Directed Model

EDCD individuals enrolled in the VALTC program may receive personal care, adult day health care (ADHC), respite, and personal emergency response system (PERS) through an agency-directed model of care. Agency directed care is the traditional method of service delivery; where an entity, such as a personal care agency or home health agency, employs the personal care attendant and arranges for him or her to provide services for the participant. The majority of current EDCD participants use traditional "agency" directed services.

For agency-directed care, the participant must have a viable back-up plan (e.g. a family member, neighbor, or friend willing and available to assist the individual) in case the attendant is unable to work for any reason. A back-up plan is the responsibility of the participant and family and must be identified in the plan of care. Participants who do not have viable back-up plans are not eligible for services until a viable back-up plan has been developed and implemented.

Consumer-Directed (CD) Model

Participants who receive personal and respite care also have the option of "consumer-directing" their care. This model allows the participant to serve as the employer of the attendant, in which the participant is responsible for hiring, training, supervising, and firing the attendant. The consumer-directed model of care is freely chosen by the individual or their designated representative, if the individual is not able to make a choice.

Under the consumer-directed model, MCOs will have the option of supporting the participant in his or her role as the CD employer by providing a MCO staff member or by contracting with area provider to provide the following services. In the current EDCD Waiver program, individuals who support individuals in their role as the employer are known as "service facilitators." Service facilitators currently provide CD employer support to Medicaid waiver participants in the Tidewater area.

For consumer-directed care, the participant must have a viable back-up plan (e.g. a family member, neighbor, or friend willing and available to assist the individual) in case the attendant is unable to work for any reason. A back-up plan is the responsibility of the participant and family and must be identified in the plan of care. Participants who do not have viable back-up plans are not eligible for services until a viable back-up plan has been developed and implemented.

Consumer-directed employer support requirements include the following activities:

a. Initial Comprehensive Visit: The MCO or its contracted provider shall be responsible for initiating services with the participant. The MCO shall make an initial comprehensive home visit for any new participant of consumer-directed services prior to the start of care. During the visit, the MCO shall identify, with the participant or their designated representative, all individual needs to be addressed in

the Plan of Care. The MCO shall develop a safe, appropriate Plan of Care with the participant that meets the identified needs of the participant.

The MCO shall provide the participant with a copy of the Employer Manual located at http://www.dmas.virginia.gov/downloads/pdfs/prm-CDS_Comm_Waiv_Manual.pdf to ensure that the participant understands his or her rights and responsibilities in the program and signs all of the Participation Agreements found in the Employer Manual. These forms must be signed before the participant can begin employing an attendant. The MCO shall send the original Fiscal Agent Contract to the Fiscal Agent (if the MCO is contracting for this service) and keep a copy for the participant's file, and provide a copy to the participant.

A hire packet must be obtained from the MCO and provided to the participant or his or her designated representative. The MCO shall provide needed assistance to ensure its completion.

b. Consumer/Employer (Individual) Training: The MCO, using the Employee Management Manual, shall provide the participant with training on his or her responsibilities as employer within seven days of completion of the comprehensive visit. (The MCO or its contracted provider can complete the comprehensive visit and individual training on the same day, if appropriate). The MCO must train the participant on his or her duties as an employer. To assure that the training content for Employee Management Training meets the acceptable requirements, the MCO must use, at a minimum, the curriculum provided by DMAS http://www.dmas.virginia.gov/downloads/pdfs/ltc-Complete_PCA_Curriculum_020103.pdf. The MCO shall also follow the checklist outlined in the Consumer-Directed Participant Comprehensive Training Form. This is an outline of the minimum items that DMAS requires covered in the training. The MCO must check each item on the form after it has been covered, and obtain the required signatures and dates. This form must be maintained in the participant's files and be available for review by DMAS staff.

This training is designed for the participant of services (or their designated representative, as appropriate).

c. Routine On-site Visits: After the initial comprehensive visit, the MCO or its contracted provider shall conduct two on-site, routine visits within 60 days of the comprehensive visit to monitor the participant's Plan of Care and assess the quality and appropriateness of the services being provided. After the two routine on-site visits, the MCO and participant together will decide how frequently the routine on-site visits will be conducted. A face-to-face meeting with the participant must be conducted at least every six months when consumer direction is the only long-term care service a participant receives, in order to ensure appropriateness of services. The MCO shall provide any necessary supervision to the participant and record all significant contacts in the participant's file.

During visits with the participant, the MCO shall observe, evaluate, and consult with the participant, his or her designated representative, or both, and document the adequacy and appropriateness of the CD services with regards to the participant's current functioning and cognitive status, medical and social needs, and the established Plan of Care. The attendant's record may be reviewed, and the participant's satisfaction with the type and amount of service must be discussed. Changes shall be made if the Plan of Care is not adequate.

If a health and/or safety issue is noted by the MCO during a visit, he/she is obligated as a mandated reporter to report this to Adult Protective Services toll-free at 1-888-832-3858 or to their local department of social services.

The MCO's documentation of this visit may be in the form of a SOAP note (*Subjective* information obtained from the participant, *Objective* information observed by the MCO, *Assessment* based on the subjective and objective information, *Plan* the best care for the participant), or the MCO may use or require the use of a standardized form to record the visit. The Consumer-Directed Services Individual Assessment Report (DMAS-99) is available at http://www.dmas.virginia.gov/downloads/forms/DMAS-99.pdf .

During the routine onsite visits, the MCO must document:

i. Whether CD services are adequate to meet the participant's needs and whether changes to the Plan of Care are needed;
ii. Any suspected abuse, neglect, or exploitation and to whom it was reported;
iii. Hospitalization or change in medical condition, functioning, cognitive status, or social support;
iv. The participant's and/or his or her designated representative (as appropriate) satisfaction with services;
v. The presence or absence of the attendant in the home during the visit;
vi. Any change in the employment of the attendant. The MCO must note this in the participant's file and ensure that the criminal history record check is performed on this new employee; and
vii. Dates of and reasons for any service lapses (hospitalization admission, attendant not available, etc.).
viii. In addition, there are several areas (such as bowel/bladder programs, range of motion exercises, catheter and wound care, etc.) that, when ordered by a physician are part of a participant's Plan of Care require monitoring by the participant's primary health care professional or a RN. RN delegation is to be within the scope of 18VAC90-20-420 though 18VAC90-20-460 of the Virginia Administrative Code, which allows an unlicensed person to be supervised and monitored by a RN.

d. Reassessment Visit: Once every six months, the MCO or its contracted provider shall meet with the participant and his or her designated representative (if the participant would like for this individual to be included) to conduct a reassessment of the participant's current functional and social support status and a complete summary of all services. Documentation of the reassessment visit must include a complete review of the participant's needs and available supports and a review of the Plan of Care. In order to ensure consistency across the Medicaid long-term care programs and meet DMAS Federal reporting requirements, the reassessment visit must be documented on a DMAS-99.

   In addition, the MCO or its contracted provider shall conduct a reassessment visit for participants who are transferring from another VALTC MCO, who select a different CD employer support provider (if the MCO is not providing this service), or request a change in their CD services. During the reassessment visit, the MCO or its contracted provider and participant together decide how frequently the routine on-site visits will be conducted.

e. During visits to the participant's home, the MCO or its contracted provider shall observe, evaluate, and document the adequacy and appropriateness of services.

f. Monitoring: The MCO or its contracted provider shall be responsible for training a participant regarding his or her responsibilities as an employer; making an increase/decrease to the participant's Plan of Care as needed; consulting with the participant or his or her designated representative as needed; discussing with the participant the need for additional long-term care services; or contacting DMAS to request a special review of the participant's case. Anytime the MCO is unsure of the action that needs to be taken, the MCO shall contact the DMAS VALTC transition coordinator.

g. Availability: The MCO or its contracted provider shall be available by telephone to individuals receiving CD services during normal business hours, have voice mail capability, and return phone calls within 24 hours.

h. Management Training: This training is provided by the MCO or its contracted provider upon the request of the participant or his or her designated representative. The MCO shall not use this to train the attendant.

i. Criminal Record Check: All CD attendants must complete a criminal record check. VALTC MCOs or their contracted Fiscal Agent shall assist participants by submitting the criminal record check forms to the aide to the Virginia State Police on behalf of the attendant prior to the start of CD services and whenever the participant hires a new attendant. VALTC MCOs or the subcontracted Fiscal Agent shall pay the fee for a criminal record check on behalf of the participant. The MCO shall provide the participant or his or her designated representative with the results of the criminal history record check and document in the participant's record that the participant or his or her designated representative has been informed of the results. If the attendant has been convicted of crimes described in 12 VAC 30-90-180, the attendant will no longer be reimbursed under this program for services provided to the participant effective the date the criminal record was confirmed. The MCO or Fiscal Agent shall be responsible for notifying the participant, his or her designated representative, and the MCO or Fiscal Agent (as appropriate) when an attendant is found to have been convicted of any of the applicable crimes.

j. Participants have the right to choose, hire, and employ an attendant whom they know has been convicted of a crime that is not prohibited in the applicable sections of the Code of Virginia 32.1-162.9:1. When doing so, participants and his or her designated representative must understand that the decision and consequences thereof are their sole responsibility.

k. Verification of Time Sheets: The MCO or its contracted Fiscal Agent must have the patient pay information (currently the DMAS-122) for use in processing time sheets. The MCO shall review copies of the time sheets during routine on-site visits to ensure that the hours of service provided are consistent with the Plan of Care. If the participant is unable to sign the time sheet and no other representative is able to sign, the participant may make an "X." If the participant is unable to sign or make an "X," the MCO shall make a notation in the front of the participant's record that "participant is unable to sign."

l. If discrepancies are identified in the time sheets, the MCO or Fiscal Agent (as appropriate) shall contact the participant or designated representative to resolve discrepancies. If an attendant consistently has discrepancies in his or her time sheets and training has been offered, the MCO shall meet with the participant or his or her designated representative to determine if CD services remain appropriate (i.e., that the participant or his or her designated representative can manage the services).

Service criteria are described in detail in the EDCD regulations at 12VAC30-120-950 and 12VAC30-120-960 and the provider manual at http://websrvr.dmas.virginia.gov/manuals/edcd/EDCD_chapter_4.pdf.

5.21.4 Environmental modifications

Environmental Modifications are physical adaptations to an individual's home, primary place of residence, primary vehicle, and, in some instances, a workplace, which provide direct medical or remedial benefit to the individual. These adaptations are necessary to ensure the health, welfare, and safety of the individual, or enable the individual to function with greater independence in the home and work site. Without these adaptations, the individual would require institutionalization.

All services shall be provided in accordance with applicable state or local building codes.

a. The modifications and activities are:
    i. Physical adaptations to a house or primary place of residence necessary to ensure an individual's health or safety (installation of specialized electric and plumbing systems to accommodate medical equipment and supplies, etc.);
    ii. Physical adaptations to a house or place of residence that enable an individual to live in a non-institutional setting and to function with greater independence that do not increase the square footage of the place of residence (installation of ramps and grab-bars, widening of doorways, modifications to bathroom facilities, etc.);
    iii. Environmental modifications to the work site (which exceed reasonable accommodation requirements of the Americans with Disabilities Act); and
    iv. Modifications to the primary vehicle being used by the individual. This service does not include the purchase of vehicles.

b. To qualify for environmental modifications, the Department's current standards require that the individual have a demonstrated need for equipment or modifications of a remedial or medical benefit offered primarily in an individual's home, vehicle, community activity setting, or day program to specifically improve the individual's personal functioning. This service encompasses those items not otherwise covered in the Virginia State Plan for Medical Assistance or through another program.

    The MCO could possibly work with four different providers in order to complete one modification, for example:
    i. A Rehabilitation Engineer or Rehabilitation Specialist may be used to evaluate the individual's needs and subsequently act as Project Manager, assuring functionality of the environmental modification through quality assurance inspections once the project is finished. Alternatively, the Rehabilitation Engineer may actually design and personally complete the modification. A Physical Therapist, Speech Therapist, or Occupational Therapist, available through the Virginia State Plan for Medical Assistance or EDCD Waiver Therapeutic Consultation, may also be utilized to evaluate the needs for environmental modifications;
    ii. A Building contractor that may design and complete the structural modification;
    iii. A vendor who supplies the necessary materials may be separately reimbursed or supplies may be included in the bill of the Building contractor or Rehabilitation Engineer; or
    iv. A Durable Medical Equipment (DME) provider who would perform and bill for modifications.

    A Rehabilitation Engineer might be required if (for example):
    i. The Environmental Modification involves combinations of systems which are not designed to go together; or
    ii. The structural modification requires a Project Manager to assure that design and functionality meet ADA accessibility guidelines.

c. The maximum Medicaid-funded expenditure is $5,000 of environmental modifications per plan year. Costs for Environmental Modifications cannot be carried over from one plan-of-care (POC) year to the next and must be pre-authorized each POC year.

    Modifications should not be used to bring a substandard dwelling up to minimum habitation standards. This service does not include those adaptations or improvements to the home, which are of general utility and are not of direct medical or remedial benefit to the individual (i.e. carpeting, roof repair, central air conditioning, etc.). Adaptations that add to the total square footage of the home are

not allowable expenditures. Also excluded are modifications that are reasonable accommodation requirements of the Americans with Disabilities Act, Virginians with Disabilities Act, and the Rehabilitation Act.

Service criteria are described in detail in the proposed regulations at 12VAC-30-120-758(D) http://www.townhall.state.va.us/L/ViewXML.cfm?textid=1628

5.21.5 Personal care services: agency-and consumer-directed

Personal care services means direct assistance with activities of daily living (ADLs), instrumental activities of daily living, supervision, and monitoring of health status and physical condition. Personal care is available as either agency-directed (AD) or consumer-directed (CD). These services may be provided in home and community settings to enable a participant to maintain the health status and functional skills necessary to live in the community, or to participate in community activities. The participant must require assistance with ADLs in order for personal care services to be authorized.

The unit of service for personal care services is one hour. In the current DMAS EDCD program, payment is available only for allowable activities that are authorized and provided by a qualified provider in accordance with an approved Plan of Care when the participant is present. Personal care services are limited to the hours specified in the Plan of Care.

Personal assistance services include assistance with Activities of Daily Living (ADL): eating, bathing, dressing, transferring, toileting, supervision, and medication monitoring and monitoring of health status and physical condition. This service does not include skilled nursing services with the exception of skilled nursing tasks that may be delegated pursuant to the Virginia Administrative Code 18VAC90-20-420 through 18VAC90-20-460. When specified in the service plan, personal assistance services may include assistance with Instrumental Activities of Daily Living (IADL), such as bedmaking, dusting, vacuuming, shopping, and meal preparation, but does not include the cost of meals themselves. Assistance with IADLs must be essential to the health and welfare of the individual, rather than the individual's family. These services substitute for the absence, loss, diminution, or impairment of a physical, behavioral, or cognitive function. Provision of these services is not limited to the home.

An additional component to personal assistance is work-related or school-related personal assistance. This allows the personal assistance provider to offer assistance and supports for individuals in the workplace and for those individuals attending post-secondary educational institutions. This service is only available to individuals who require personal assistance services to meet their ADLs. Workplace or school supports through the EDCD Waiver are not provided if they are services provided by the Department of Rehabilitative Services, under IDEA, or if they are an employer's responsibility under the Americans with Disabilities Act of Section 504 of the Rehabilitation Act.

Individuals are afforded the opportunity to act as the employer in the self-direction of personal care services for the EDCD Waiver. This involves hiring, training, supervision, and termination of self-directed care assistants. Participants choosing to receive services through the CD model may do so by receiving the training and guidance needed to be an employer from the MCO or its contracted provider. If the participant is unable to independently manage his/her own CD services, a spouse, guardian, or adult child must serve as the employer on behalf of the participant.

Service criteria are described in detail in the EDCD regulations at 12VAC30-120-950 and 12VAC30-120-960 and the provider manual at http://websrvr.dmas.virginia.gov/manuals/edcd/EDCD_chapter_4.pdf

5.21.6 Personal Emergency Response System (PERS)

Personal Emergency Response System (PERS) is an electronic device that enables certain individuals to secure help in an emergency. PERS electronically monitors participant safety in the home and provides access to emergency crisis intervention for medical or environmental emergencies through the provision of a two-way voice communication system that dials a 24-hour response or monitoring center upon activation and via the participant's home telephone line. When appropriate, PERS may also include medication monitoring devices.

PERS services are limited to those participants who live alone, are alone for significant parts of the day, have no regular caregivers for extended periods of time, or when there is no one else in the home who is competent or continuously available to call for help in an emergency and who would otherwise require extensive routine supervision. Participants must be receiving PERS services and another EDCD Waiver service simultaneously. While medication monitoring services are also available to those receiving PERS services, medication monitoring units must be physician ordered and are not considered a stand-alone service.

Service criteria are described in detail in the EDCD regulations at 12VAC30-120-970 and the provider manual at http://websrvr.dmas.virginia.gov/manuals/edcd/EDCD_chapter_4.pdf

5.21.7 Respite care services – agency and consumer-directed

Respite services are personal care (agency-directed or consumer directed) or services of a nurse (agency-directed) that are specifically designed to provide temporary, substitute care that is normally provided by the family or another unpaid primary caregiver of a participant. Respite is for the relief of the caregiver due to the physical burden and emotional stress of providing continuous support and care to the participant. These services are provided on a short-term basis because of the emergency absence, or need for routine or periodic relief, of the primary caregiver who lives in the home with the participant.

The maximum amount of respite care services that a participant may receive in the current DMAS program is 720 hours in a calendar year. In the DMAS EDCD program, participants who are receiving consumer-directed, agency-directed, and facility-based respite services cannot exceed 720 hours per calendar year combined. Respite care can be authorized as a sole community-based care service, or it can be offered in conjunction with other waiver services.

Respite services are usually provided by a personal care attendant. However, a licensed nurse may provide skilled respite in cases where the participant has a skilled nursing need, provided the circumstances warranting provision of skilled respite by a nurse are:

i. A physician's order must be obtained prior to the start of skilled respite services and must be kept in the participant's record. The order must be renewed every six (6) months;
ii. The participant receiving care has a need for skilled care that cannot be provided by unlicensed personnel (e.g., patients on a ventilator, patients requiring nasogastric or gastrotomy feedings, suctioning, etc.);
iii. No other individual in the recipient's support system is able to provide the skilled component of the participant's care during the caregiver's absence; and
iv. The participant is unable to receive skilled nursing visits from any other source, including home health, which could provide the skilled care usually given by the caregiver.

Service criteria for respite (non-skilled and skilled) are described in detail in the EDCD regulations at 12VAC30-120-960 and the provider manual at
http://websrvr.dmas.virginia.gov/manuals/edcd/EDCD_chapter_4.pdf

5.21.8 Transition services and transition coordination (carved-out services)

Transition coordination and services shall be provided to EDCD participants in the VALTC program as a carved-out service and reimbursed by DMAS under the FFS system.

Transition Services

Transition services cover specific expenses for individuals who are transitioning from an institution or licensed or certified provider-operated living arrangement, to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses. For the purposes of transition services, an institution means an ICF/MR, a nursing facility, or a specialized care facility/hospital as defined at 42CFR435.1009. Transition services do not apply to an acute care admission to a hospital. Services are available for one transition per individual and must be expended within nine months from the date of authorization. The total cost of these services shall not exceed $5,000, per-person lifetime limit coverage.

In order to be provided, transition services shall be prior authorized by DMAS or its designated agent. These services include rent or utility deposits, basic furniture and appliances, health and safety assurances, and other reasonable expenses incurred as part of a transition. The DMAS designated fiscal agent shall manage the accounting of the transition service. The transition coordinator for the EDCD Waiver or the case manager or health care coordinator, as appropriate to the waiver, shall ensure that the funding spent is reasonable and does not exceed the $5,000 maximum limit.

Allowable costs include, but are not limited to:

i. security deposits that are required to obtain a lease on an apartment or home;
ii. essential household furnishings required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens;
iii. set-up fees or deposits for utility or services access, including telephone, electricity, heating and water;
iv. services necessary for the individual's health, safety, and welfare such as pest eradication and one-time cleaning prior to occupancy;
v. moving expenses;
vi. fees to obtain a copy of a birth certificate or an identification card or driver's license; and
vii. activities to assess need, arrange for, and procure needed resources.

The services are furnished only to the extent that they are reasonable and necessary as determined through the service plan development process, are clearly identified in the service plan and the person is unable to meet such expense or when the services cannot be obtained from another source. The expenses do not include monthly rental or mortgage expenses; food; regular utility charges; and/or household items that are intended for purely diversional/recreational purposes. This service does not include services or items that are covered under other waiver services such as chore, homemaker, environmental modifications and adaptations, or specialized supplies and equipment (assistive technology).

Transition Coordination

Transition coordination is provided by the DMAS-enrolled provider who is responsible for supporting the individual and his or her designated representative, as appropriate, with the activities associated with transitioning from an institution to the community pursuant to the Elderly or Disabled with Consumer-Direction waiver. The MCO must work with DMAS or its' provider to anticipate, plan, and manage the transition process.

Transition coordination services include, but are not limited to, the development of a transition plan; the provision of information about services that may be needed, in accordance with the timeframe specified in federal law, prior to the discharge date, during and after transition; the coordination of community-based services with the case manager, if case management is available; linkage to services needed prior to transition such as housing, peer counseling, budget management training, and transportation; and the provision of ongoing support for up to 12 months after discharge date.

The individual's service plan shall clearly reflect the individual's needs for transition coordination provided to the individual, his or her designated representative, and providers in order to implement the service plan effectively. The service plan includes, at a minimum: (i) a summary or reference to the assessment; (ii) goals and measurable objectives for addressing each identified need; (iii) the services, supports, and frequency of service to accomplish the goals and objectives; (iv) target dates for accomplishment of goals and objectives; (v) estimated duration of service; (vi) the role of other agencies if the plan is a shared responsibility; and (vii) the staff responsible for coordination and integration of services, including the staff of other agencies if the plan is a shared responsibility.

Service criteria are described in detail in the proposed regulations at 12VAC-30-120-70
http://www.townhall.state.va.us/L/ViewXML.cfm?textid=1628

5.21.9 EDCD Waiver Services CPT Codes

Service	Procedure Code
Adult Day Health Care	(S5012)
Personal Care: Provided by an agency	(T1019)
PERS Installation	(S5160)
PERS Monitoring	(S5161)
PERS Medication Monitoring Installation	(S5160 U1)
PERS Medication Monitoring	(S5185)
PERS RN Monitoring	(H2021 TD)
PERS LPN Monitoring	(H2021 TE)
Respite Care: Provided by an agency	(T1005)
Skilled Respite Care: Provided by an agency	(S9125 TE)
Environmental Modifications	(S5165)
Assistive Technology	(T1999)
Service Facilitation for Consumer Directed Services:	
Comprehensive Visit	(H2000)
Consumer Training	(S5109)
Management Training	(S5116)
Reassessment Visit	(T1028)
Routine Visit	(99509)
Consumer Directed Services (paid via invoice to PPL- claims not directly paid by DMAS):	
Criminal Record Check	(99199-U1)
Personal Care	(S5126)
Respite Care	(S5150)
EDCD Waiver Services Carved Out (Paid in FFS System)	
Transition Coordination*	(H2015)
Transition Services*	(T2038)

5.21.10 DMAS Reimbursement Rates for EDCD Services

Waiver Services 2007 chart- revised 03/24/2007	**Reimbursement Rate for Service Rest of State** (effective 07/01/07)
Adult Day Health Care - S5102	$46.11/day
Assistive Technology- T1999	$5,000 max/yr
Environmental Mods- S5165	$5,000 max/yr
Medication Monitoring – Installation- S5160 UI	$75.00
Medication Monitoring – Monthly- S5185	$50.00/month
Personal Care – Agency - T1019	$12.53/hour
Personal Care – Consumer Directed – S5126	$8.60
PERS Installation- S5160	$50.00
PERS Monitoring - S5161	$30.00/month
PERS – RN- H2021 TD	$12.25/.25 hour
PERS – LPN- H2021 TE	$10.25/.25 hour
Respite Care - Agency (PC)- T1005	$12.53/hour
Respite Care - Consumer Directed - S5150	$8.60

5.22 Screenings and Assessments

5.22.1 Uniform Assessment Instrument (UAI)

Virginia uses the Uniform Assessment Instrument (UAI) to assess level of care criteria for EDCD Waiver participants. The purpose of the UAI is to gather information for the determination of a client's care needs and service eligibility, and for planning and monitoring a client's care across various agencies and long-term care services. The UAI is a multidimensional, standardized questionnaire, which assesses a client's social, physical health, mental health, functional abilities, and cognitive disabilities, etc., and it provides a comprehensive look at a client. The UAI fosters the sharing of information between providers, and assessors are encouraged to share information about a client to avoid duplicative paperwork.

For initial level of care evaluation, the Pre-Admission Screening Team (contracted through the Virginia Departments of Health and Social Services) or an acute care hospital uses the UAI to evaluate the individual's care needs and service eligibility. The individual's service plan is developed based on information obtained from the UAI. The Pre-Admission Screening Team is responsible for notifying individuals of the choice between institutional and community-based services, the choice of waiver program or PACE, and MCO options if the individual chooses the EDCD Waiver within the VALTC program. Participants under the VALTC program must select from two or more MCOs in the localities, and must utilize the provider network within their selected plan. Individuals who meet criteria for the EDCD Waiver and who live in a VALTC program region shall be enrolled as a VALTC program participant. The data collected from the UAI will be sent to the MCO by DMAS as part of the transition report.

The UAI may be found at http://www.dss.virginia.gov/files/division/dfs/as/forms/032-02-0166-00-eng.pdf and the UAI User's Manual at http://www.dss.virginia.gov/files/division/dfs/as/uai_manual/manual.pdf.

Pre-admission screening criteria is available at http://websrvr.dmas.virginia.gov/manuals/NHPAS/appendixB_nhpas.pdf

5.22.2 Service plan development

In accordance with 42 CFR §441.301(b)(1)(i), the MCO shall develop a person-centered service plan (of care) for each waiver participant. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The MCO shall be responsible for service plan development for individuals choosing consumer-direction of care. The MCO's service plan template is subject to the approval of DMAS. Services furnished prior to the development of the service plan or for services that are not included in the service plan are not covered.

The MCO shall take steps to assure that recipients who are newly enrolled into the EDCD waiver on a weekly basis as outlined in Section 5.3.3.1 receive an initial face-to-face screening and assessment, and begin receiving long-term care services within 30 days of enrollment into the EDCD waiver. This minimum requirement shall be evaluated annually.

For the initial migration of EDCD recipients who receive services via the fee-for-service program prior to VALTC program implementation, the MCO shall take steps to ensure that recipients receive a contact (via phone or face-to-face) within 90 calendar days of the initial health plan enrollment to discuss the individual's needs, existing supports and providers, and to develop a preliminary plan of care identifying needed services. If the recipient's annual level-of-care (LOC) review date, as indicated on the MCO transition report, is prior to the 90 calendar day assessment, the MCO shall conduct the annual LOC.

The service plan development process shall be person-centered and include appropriate assessments to identify participant needs, preferences, goals, and health status. The service planning process shall include coordination of services and methods for updating the plan on a periodic basis or as prompted by changes in the participant's needs. The plan development process shall assign implementation responsibilities and include monitoring methods.

Service plan development and service provision monitoring must include a review of:

i. services being furnished in accordance with the service plan;
ii. access of the waiver participant to the services identified in the service plan, either by the provision of waiver services or through other means;
iii. choice of provider(s) by the waiver participant;
iv. participant's needs being met by services identified in the service plan;
v. back-up plans and their effectiveness;
vi. health, safety, and welfare of the waiver participant;
vii. access to services not covered by the waiver, including health care needs.

If issues with any of the above are identified by the MCO, it must be documented, including methods to address, in the waiver participant's record.

Participants should be encouraged to direct and actively engage in the person-centered service plan development process and shall have the authority to determine who is included in the process. The service plan shall be developed in consultation with the primary care physician, the participant, other pertinent specialists, and family or significant others involved in the recipient's care. Care coordination is a key element in the oversight and success of this program, the goal of which is to provide accessible, comprehensive and quality services. The MCO shall use a service planning process that promotes participant-centered planning and involvement of the participant in the planning process.

The MCO shall be required to include risk assessment and mitigation as a part of the service plan development process. The MCO takes into account the services and supports needed as well as the supports that are already in place to mitigate risk.

For both agency-directed and consumer-directed care, the waiver participant must have a viable back-up plan (e.g. a family member, neighbor or friend willing and available to assist the individual, etc.) in case the personal care or respite care assistant is unable to work as expected or terminates employment without prior notice. This is the responsibility of the waiver participant and family and must be identified in the service plan. Waiver participants who do not have viable back-up plans are not eligible for services until viable back-up plans have been developed. The MCO shall assist the individual in identifying and selecting individuals or agencies that will be identified as the viable back-up method.

The plan of care outlines back-up plan provisions for all other services requiring a back-up plan, either by the provision of waiver services or through other means. The individual is supported in selecting a variety of back up measures including, but not limited to, natural supports in the community, additional consumer-directed employees, or agency-directed resources. As the needs of the individual evolve, additional services requiring back-up plans and the method to address can be added to the plan of care through the MCO.

EDCD Waiver participants in the VALTC program shall have their service plan developed by the MCO. The service plan review and approval shall be performed by a Registered Nurse employed by or contracted with the MCO. Service plan development must be overseen by an individual who possesses a BA/BS or higher in a health or human service related field and/or licensure as a health professional, certification as a care manager, or current unrestricted RN license. In addition, 3 years clinical experience or any combination of education and experience, which would provide an equivalent background, is recommended. This requirement includes knowledge of care management assessment technique, provider community, and community resources. One year experience in home health/discharge planning or care management is preferred along with strong oral, written and interpersonal communication skills, organizational and problem-solving skills, and decision-making skills.

All service plans are subject to review by the MCO via the Quality Management Review (QMR) process to assure that services are approved and appropriate for the participant. The purpose of the Quality Management Review (QMR) is to determine whether services delivered were appropriate, continue to be needed by the participant, and the amount and kind of services were required. QMR reviews done by the MCO include a review of the participant's record, evaluation of the participant's medical and functional status, and consultation with the waiver participant and family/caregiver, as appropriate. Specific attention is paid to all applicable documentation, which may include service plans, RN supervisory notes, care coordinator notes, daily logs, personal assistant time sheets, progress notes, screening packages, and any other documentation necessary to determine if appropriate payment was made for services delivered.

Additional QMR conducted by DMAS provides additional monitoring and oversight of service plan development and health, safety and welfare safeguards. The MCO will provide DMAS Long Term Care (LTC) QMR staff with a sample of service plans. DMAS LTC QMR staff will review this sample to ensure there were timely service plan revisions, and that recipient health and welfare assurances were met. Service plans also will be reviewed to assure adequacy of service plan and to ensure plans are providing services in same amount, duration, and scope as specified in plan.

A financial review of providers shall be included as a part of the MCO quality review process. The purpose of the financial review and verification of services is to ensure the provider bills only for those services which have been provided in accordance with DMAS policy, are approved in the service plan and are covered by the EDCD Waiver.

The MCO shall maintain service plan forms for a minimum of three years as outlined by the Code of Federal Regulations.

5.22.3 Re-Evaluation

Once an individual is enrolled in VALTC, the MCO shall be responsible for conducting the annual level of care (LOC) re-evaluations (form available at http://www.dmas.virginia.gov/downloads/forms/DMAS-99.pdf). The MCO shall complete all of the required assessments for the LOC annual review and submit summaries to DMAS for reporting purposes. DMAS staff will also conduct sample reviews of level of care evaluations conducted by MCO for quality control purposes. In the event the MCO determines that the participant no longer meets criteria, the LOC review information will be automatically forwarded to DMAS for an administrative review and final determination of continued program eligibility.

Annual level of care reevaluations are completed by:

i. A registered nurse, licensed in Virginia;
ii. A social worker;
iii. An individual who holds at least a bachelor's degree in social work or in a human services field. If the person does not have a bachelor's degree, s/he must have at least two years of experience working with individuals who are elderly and/or have disabilities.

The MCO will receive the initial assessment date for each EDCD Waiver participant who enrolls in the VALTC Program and will be responsible for ensuring timely completion of annual level of care reevaluation.

The MCO shall maintain the initial level of care evaluation and reevaluation documentation for a minimum period of three years as required by the Code of Federal Regulations. Aggregate data from the MCOs will be maintained by DMAS for reporting purposes.

The External Quality Review Organization (EQRO) will be responsible for monitoring the MCO's processes related to the development and re-evaluation of service plans. DMAS will also provide program oversight to ensure evaluations and reevaluations are completed appropriately and timely, and that the MCO meets established reporting requirements.

5.23 Patient Pay Amount

Each waiver recipient is allowed to keep a portion of his or her income for personal needs. This is called a personal maintenance allowance (PMA). The PMA is higher for an individual staying at home receiving community-based care than for an individual in a nursing facility. The base PMA for recipients of the EDCD Waiver is usually equal to 165% of the current Supplemental Security Income (SSI) individual payment standard.

When a recipient's income exceeds allowable deductions the PMA, he or she must contribute toward the cost of long-term care services. This contribution, known as the "patient pay," is required for individuals residing in a nursing facility and for those receiving home and community-based services.

In the current fee-for-service long-term care system, the provider with the most authorized hours is considered the primary service provider and responsible for the collection of any patient pay amounts indicated by DMAS. In VALTC, the contracted MCO shall administer and track collection of the patient pay. It will be up to the MCO as to which long-term care provider is deemed the primary provider who will collect the patient pay. The MCO will notify this provider that he is to collect the patient pay and provide the amount of the patient pay to the provider.

The patient pay is collected from participants by the primary service provider on a monthly basis. Typically, the patient pay amount is the same each month and adjusted annually at the end of the calendar year to account for a cost of living adjustment. A small number of participants, however, will have their patient pay amount adjusted several times during the year to account for changes in their financial circumstances.

DMAS will provide the patient pay amount to the MCO via the transition report and the MCO shall decrease the primary provider's reimbursement by the patient pay amount. Capitation rates incorporate collection of the patient pay. The MCO or its designee must document the patent pay amount for the current service year is in the recipient's record.

If the amount of services rendered by the primary provider is less than the recipient's patient pay for a given month, the primary provider must contact the MCO and the MCO will let the provider with the next most authorized service hours know that he is to collect the balance of the patient pay amount. When multiple providers are involved in the recipient's care, the MCO shall coordinate the patient pay process with the providers. If the amount of services rendered by the primary provider is equal to the recipient's patient pay for a given month, the provider will not bill the MCO for services rendered.

If a provider agency does not know if the recipient is receiving other waiver services or if it should be collecting the patient pay, the provider will contact the MCO to obtain this information.

5.23.1 DMAS-122

The Patient Information Form (DMAS-122) currently is used by the DSS to inform providers of Medicaid eligibility and to exchange information. DMAS shall provide this information to the MCOs via the transition report. DMAS plans to have this process automated prior to the launch of VALTC. A new DMAS-122 is generated at least annually, or when the recipient's patient pay changes. The MCO or its designee must ensure that a completed DMAS-122 for the current service year is in the recipient's record. When multiple providers are involved in the recipient's care, the MCO shall coordinate the DMAS-122 process with the providers.

5.23.2 Patient pay collection for consumer direction (CD) as the primary service

If CD service is the most authorized service the recipient is receiving, patient pay amount must be provided to the Fiscal Agent, if applicable, as soon as possible so that the patient pay amount can be deducted from the CD personal care attendant's payroll.

5.23.3 Respite care as the sole service

Respite care providers are only responsible for collecting the patient pay when respite care is the sole service authorized.

If the amount of services rendered by the primary provider is less than the recipient's patient pay for a given month, the primary provider must contact the provider with the next most authorized service hours with the balance of the patient pay amount that has not been collected from the recipient. This secondary provider will be responsible for collecting the patient pay balance. When multiple providers are involved in the recipient's care, the MCO shall coordinate the patient pay process with the providers.

If the amount of services rendered by the primary provider is equal to the recipient's patient pay for a given month, the provider will not bill the MCO for services rendered.

5.24 Consumer-Directed Fiscal/Employer Agent (F/EA) Services

There are many Virginians who are elderly or have a disability and are able to direct their own care. Many will be able to achieve greater independence if they hire and manage their own attendants rather than depend solely on home health care/nurses/aides or family members. Under the traditional system of personal care, elderly individuals and persons with disabilities are dependent upon the schedules of personal care agency staff. Because of this, services are usually available only during limited hours (seldom at night or on the weekends). Individuals have needs throughout the entire week and benefit from a system allowing the flexibility to obtain services when needed.

Consumer-directed services through Medicaid-funded home-and-community-based waivers allow Medicaid recipients to serve as common-law employers, responsible for directing their own care and hiring, training, supervising and firing their attendants. For recipients who are who are not able to self-direct their own attendants, a representative (as defined in the EDCD waiver manual http://websrvr.dmas.virginia.gov/manuals/edcd/edcd.htm) is also eligible to act as the common-law employer on the recipient's behalf.

Projection of consumer-direction is challenging because of the difficulty of accurately predicting program growth. Factors include legislative mandates, or external challenges that may alter growth in numbers served.

Attendants providing consumer-directed services are selected and supervised by the Medicaid recipients. Attendants are subject to Federal and State tax employment withholdings as domestic workers, working for household employers.

Each attendant hired by the recipient receiving waiver services shall meet the following DMAS qualifications:

i. Be 18 years of age or older;
ii. Possess basic math, reading, and writing skills in the English language;
iii. Have the required skills to perform services as specified in the recipient's plan of care;
iv. Possess a valid Social Security number;
v. Be eligible for employment in the United States;
vi. Submit to a criminal history record check. For consumer-directed services, the attendant will not be compensated for services provided to the recipient if the record check verifies the attendant has been convicted of barrier crimes that are described in state regulations;
vii. Be willing to attend/receive training at the recipient's request; and
viii. Understand and agree to comply with all policies and requirements stated in the appropriate waiver manual.

An attendant cannot be the spouse of the individual who is receiving waiver services. Other family members may provide services only if there is no one else willing and able to provide the care and the waiver participant's record includes documentation that provides adequate justification that no other provider is available or suitable to provide personal or respite care assistance. All personal care and/or respite care services provided by an individual's relative(s) must be pre-authorized and monitored by the MCO. Payments to relatives are also monitored through the Quality Management Review process conducted by the Department of Medical Assistance Services. There are no limits on the amount of services that may be furnished by a relative or legal guardian.

Recipients participating in consumer-directed services will receive training in their role as a common-law employer from the MCO or its contracted provider. The MCO or its contracted provider shall assist the recipient as needed to develop a person-centered service plan that addresses the recipient's needs at home,

work, and/or in the community. Supervision is conducted by the recipient (or person directing the care) as specified in the recipient's plan of care. The MCO or its contracted provider shall provide employee management training to the Medicaid recipient and provide support in consumer-directed service delivery. The MCO or the E/FA shall conduct a criminal record check. The application(s) will be completed by the attendant and mailed to the MCO or E/FA (if applicable) prior to providing services. The application(s) will be submitted to the State Police in the county or city of the attendant's residency. The cost will be borne by the MCO. Attendants are reimbursed for care provided prior to the results of a criminal history record check unless the check verifies that the attendant has been convicted of a barrier crime. The MCO or E/FA shall notify the recipient of the criminal record checks results.

5.24.1 Volume

DMAS is providing historical data for the period January 1, 2007 through December 31, 2007 for informational purposes only. Number of checks is greater than the number of recipients because some recipients have more than one attendant. Projection of consumer-direction is challenging because of the difficulty of accurately predicting program growth. Factors include legislative mandates, or external challenges that may alter growth in numbers served. The data detailed below is not a guarantee of future volume. Offerors cannot rely on historical volumes to predict future volumes.

FIPS Code	Amount Payroll	Number of Checks	Number of Services	Number of Recipients
73	2,109.02	27	2	1
93	4,348.17	92	2	7
95	8,736.49	173	2	6
199	5,585.70	130	2	6
550	62,870.76	1,139	2	53
650	19,631.88	377	2	16
700	14,061.12	234	2	12
710	87,627.87	1,721	2	67
735	5,944.97	98	2	3
740	10,575.59	198	2	11
800	15,938.49	280	2	16
810	130,925.94	2,470	2	105
830	3,650.51	67	2	3
TOTAL	**372,006.48**	**7,006**		**306**

5.24.2 Role of the MCO as fiscal agent

The MCO shall serve as, or contract with, the Fiscal/Employer Agent (F/EA) and shall manage the F/EA services for consumer-directed recipients to ensure appropriate and timely payments are made to attendants and have State and Federal income taxes and employment taxes withheld, filed and paid in an accurate and timely manner. The F/EA's payments issued to attendants, hired directly by Medicaid recipients, shall be based on rates established in accordance with Virginia Medicaid regulations and policy manuals.

The MCO shall have the capability and experience to perform, or subcontract for, fiscal agent services for consumer-directed services as a Fiscal/Employer Agent (F/EA) operating under Title 26, Section 3504 of the IRS Code and Revenue Procedure 70-6 as outlined in Appendix G. These services include, but are not limited to, conducting criminal background checks on potential employees, managing recipient enrollment packets, maintaining current recipient authorization information, approving attendant

employment and tax-related documentation, processing payroll, calculating and depositing State and Federal tax withholdings and unemployment taxes (FICA, FUTA, SUTA). The F/EA acts as the agent to the common-law employer (Medicaid recipient) or his/her representative in accordance with Section 3504 of the IRS Code and Revenue Procedure 70-6. The organization must have a separate, specific Federal Employer Identification Number (FEIN) to file the IRS Form 2678 and selected federal tax forms on the recipient's behalf. The organization will have experience in implementing and maintaining F/EA services and end of year Federal tax processes.

The MCO shall have:

i. A current Comprehensive F/EA Policies and Procedures Manual for a similar project.
ii. A specific FEIN to file IRS Form 2678.
iii. Demonstrated experience in approving and maintaining recipient enrollment packets, employment packets, processing payroll services.
iv. A current technology-based system for receiving and processing timesheets.
v. A current computer database that has the capacities to track all F/EA related data.
vi. Developed implemented and maintained end of year Federal tax processes.
vii. A current, qualified, staffed call center with call history logs.
viii. Proven experience in developing, implementing and maintaining a record management process.
ix. A current training plan to stay current with Federal and State rules and regulations regarding vendor Fiscal/Employer agents and household employers.

The MCO, in response to this contract shall provide:

a. A description of how the functions in this section shall be accomplished: internally within the MCO's organization, subcontract with the Department's statewide F/EA MCO, or subcontract with a F/EA vendor approved by the Department.

b. A detailed narrative of how it has developed and implemented each of the required tasks listed in Appendix G;
c. A description of how it has developed internal controls to ensure the tasks are being performed accurately and within required timeframes;

d. A narrative that demonstrates that the MCO has experience providing these services and has considered all of the requirements and developed an approach that will support a successful project in Virginia;

e. A transition plan that will allow for the exchange of information and data from the current payroll processing entity without disruption to the program. The successful MCO shall ensure minimum disruption in services to recipients, attendants and Services Facilitators during the transition period.

f. A current comprehensive F/EA policy and procedure manual for a similar project and describe how it intends to meet all of the requirements outlined in Appendix G.

g. A sample of a current recipient enrollment packet that contains information about the MCO's F/EA's services and operations (e.g., roles and responsibilities of the F/EA, recipient or representative), federal and state forms the recipient will complete, sign and return to the F/EA to use Agent services (e.g., IRS Form SS-4, 2678, 8821) timesheets, pay schedule and other applicable consent and contract forms.

h. A current employment packet for recipients' employees that contain all the required forms, information, applications, and contracts and consent documents needed to enroll attendants as recipients' employees (e.g., employment application, IRS Form W-4, state Form W-4, IRS Notice 797).

5.25 MCO Referral Responsibilities

The MCO shall establish referral mechanisms to link enrollees with non-Medicaid funded providers and programs. The MCO shall maintain a current list of providers, agencies, and programs and provide the list to enrollees as needed.

The MCO shall advise the enrollees of the availability of services offered by the following programs, if appropriate to address the needs of the enrollee. The MCO shall coordinate with and refer enrollees to the following programs:

a. Assurance of Expertise in Serving Survivors of Abuse, Neglect , Exploitation and Domestic Violence

Any suspected instances of abuse, neglect, or exploitation are required by Virginia law to be reported to the Virginia Department of Social Services. Mandated reporters must report suspected abuse, neglect, and exploitation to Adult Protective Services immediately. Reports can be made through any means; there is no specified format. Any person may voluntarily report suspected abuse, neglect, or exploitation to Adult Protective Services including staff of financial institutions.

The MCO shall arrange for the provision of examination and treatment services by providers with expertise, capability, and experience in dealing with the medical/psychiatric and social aspects of services to survivors of abuse, neglect, exploitation, sexual assault and domestic violence and treatment modalities for perpetrators. Such expertise and capability shall include the ability to identify characteristics associated with perpetrators of such abuse, neglect, exploitation, sexual assault and domestic violence, demonstrated knowledge of statutory reporting requirements and local community resources for the prevention and treatment of abuse, neglect, exploitation sexual assault and domestic violence. The MCO shall include such providers in its network. The MCO shall utilize human services agencies or appropriate providers in their community.

The MCO shall notify all persons employed by or under contract to it who are required by law (mandated reporters) to report suspected abuse, neglect and exploitation and ensure they are knowledgeable about the law, their responsibilities and the identification requirements and procedures. The MCO assures that providers with appropriate expertise and experience in dealing with perpetrators and survivors of sexual abuse and domestic violence are utilized in service provision.

b. IDEA http://www.dmhmrsas.virginia.gov

The Individuals with Disabilities Education Act Early Intervention Services (IDEA-EIS) program (as described in 20 U.S.C. § 1471 and 34 C.F.R. § Part 303.12) is administered by the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services. Early intervention services include services that are designated to meet the developmental needs of an infant with a disability in any one or more of the following areas: physical, cognitive, communication, social or emotional, or adaptive development. The MCO shall refer enrollees who are potentially eligible for or qualify for Early Intervention Services to local interagency councils. The MCO shall maintain a listing of local interagency councils and shall make that listing available to all qualified enrollees.

c. The Virginia Department for the Aging (VDA) http://www.vda.virginia.gov

VDA works with 25 local Area Agencies on Aging (AAAs) as well as various other public and private organizations to help older Virginians, their families and loved ones find the services and information they need. VDA is a central point of contact for information and services. Area Agencies on Aging provide services and programs tailored to the people who live within their service areas. Each AAA has an advisory board of local citizens who are knowledgeable about the unique needs of their area. Provided is a complete list of AAA's with contact information.

VDA's objective is to help Virginians find the information and services they need to lead healthy and independent lives as they grow older. VDA's mission is to foster the dignity, independence, and security of older Virginians by promoting partnerships with families and communities. The Department for the Aging is designated by the federal government as the agency to oversee all state programs using funds provided by the federal Older Americans Act and the Virginia General Assembly. Area Agencies on Aging contract with VDA to provide services for older Virginians and their families in communities throughout Virginia.

d. The Virginia Department for the Deaf and Hard of Hearing (VDDHH) http://www.vddhh.org

The Virginia Department for the Deaf and Hard of Hearing (VDDHH) works to reduce the communication barriers between persons who are deaf or hard of hearing and those who are hearing, including family members, service providers, and the general public.

VDDHH offers programs that provide access to telecommunication services and assistive technology for Virginia citizens who are deaf, hard of hearing, deaf, blind or speech impaired, and interpreter services program includes a Directory of Qualified Interpreters and Interpreter Services Coordination.

e. The Virginia Department for the Blind and Vision Impaired http://www.vdbvi.org

The mission of the Department for the Blind and Vision Impaired (DBVI) is to empower individuals who are blind, vision impaired or deafblind to achieve their maximum levels of employment, education, and personal independence. Employment, education and personal independence can be achieved by Virginia's blind, deafblind or visually impaired citizens through services provided by DBVI's service programs and facilities which include: Vocational Rehabilitation (VR) and Rehabilitation Technology; Rehabilitation Teaching and Independent Living (RT/IL); Education Services (ES); Orientation and Mobility (O&M) services; Low Vision (LV) services; Deafblind (DB) services; the Virginia Rehabilitation Center for the Blind and Vision Impaired (VRCBVI); the Library and Resource Center (LRC); the Randolph-Sheppard vending and food service program; and the Virginia Industries for the Blind (VIB).

f. The Virginia Department of Rehabilitative Services http://www.vadrs.org

In partnership with people with disabilities and their families, the Virginia Department of Rehabilitative Services collaborates with the public and private sectors to provide and advocate for the highest quality services that empower individuals with disabilities to maximize their employment, independence and full inclusion into society.

For all referrals that require the sharing of the enrollee's medical information, the MCO shall ensure that its network providers obtain necessary written and signed informed consent from the enrollee prior to release of the enrollee's medical information. All requests for medical information shall be consistent with the confidentiality requirements of 42 C.F.R. § Part 431.300 Subpart F.

5.26 Member Services

The MCO shall maintain and staff a toll-free Member or Customer Services function to be operated at least during regular business hours and to be responsible for the following:

a. Explaining the operation of the MCO, including the role of the PCP and what to do in an emergency or urgent medical situation;

b. Assisting enrollees in the selection of a PCP and other providers;

c. Assisting enrollees to make appointments and obtain services;

d. Arranging medically necessary transportation for enrollees; and

e. Handling enrollee inquiries and grievances.

Specific standards for ensuring acceptable levels of service are as follows:

a. Waiting/Hold Times

   The MCO shall have appropriate equipment and personnel in place to ensure that daily hold time for a member service Helpline inquiry never exceeds three (3) minutes and that ninety percent (90%) of the callers, at a minimum, will reach a human voice or a hold message within twenty (20) seconds. Waiting/Hold Times reported shall include only Virginia specific program information.

b. Abandonment Rate
   The MCO's daily telephone abandonment rate for member service helpline access calls shall be less than ten percent (10%) for all incoming calls.

   Records of wait times and abandonment rates specific to Virginia Medicaid only shall be kept by the MCO and reported to the Department monthly. At a minimum the report shall identify the total call volume, wait time (in seconds), and the abandonment percentage rate.

5.27 On-line Member Website

The MCO shall have a secure internet-based website which includes, at a minimum: (1) the Department's approved MCO's member handbook, recent newsletters/announcements, MCO contact information including member services hours and closures; (2) the MCO's provider directory, available in the same format as the Department's approved provider directory, and which also allows members to electronically search for MCO panel providers based on name, provider type, and geographic proximity; and (3) the ability for members to submit questions/comments/grievances/appeals/etc. and receive a response (members must be given the option of a return e-mail or phone call) within one working day of receipt.

5.28 Care Coordination

In accordance with 42 CFR §438.208, the MCO shall have systems in place that ensure coordinated patient care for all enrollees and that provide particular attention to the needs of enrollees with complex, serious and/or disabling conditions. The systems, policies and procedures shall be consistent with the most recent NCQA standards. Such systems shall ensure the provision of primary care services, coordinated patient care, and access when necessary to specialty care services/providers. The MCO's coordination and continuity of care systems shall include provisions for all of the following processes:

a. Enrollees must have an ongoing source of primary and long-term care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the health care services furnished to the enrollee.

b. The MCO's system to coordinate patient care must include provisions to coordinate benefits and methods to prevent the duplication of services especially with transition of care activities.

c. The MCO shall ensure that the process utilized to coordinate the enrollee's care complies with enrollee privacy protections described in HIPAA regulations and in Title 45 CFR parts 160 and 164, subparts A and E, to the extent applicable.

d. The MCO's pediatric and adult primary care providers and specialists must be clinically qualified to provide or arrange for the provision of appropriate health care services. The MCO shall submit to the Department prior to signing the initial contract, upon revision or on request referral guidelines that demonstrate the conditions under which the PCPs will make the arrangements for referrals to specialty care networks.

e. The MCO shall require their contracted providers to ensure that recipients with disabilities have effective communication with health care system participants in making decisions with respect to treatment options.

The MCO shall have in place a process to develop and maintain a list of referral sources which includes community agencies, State agencies, "safety-net" providers, teaching institutions, and facilities that are needed to assure that enrollees are able to access and receive the full continuum of treatment and rehabilitative medical and outpatient mental health services and supports needed. As part of this process, the MCO shall provide discharge planning and/or coordination with long-term care service providers for enrollees who are being enrolled in home-and-community based care waivers or nursing facilities to assure continuity of care.

In accordance with 42CFR438.208(3), for each MCO that serves enrollees who are also enrolled in and receive Medicare benefits from a Medicare plan, the Department determines to what extent the MCO must meet the primary care coordination, identification, assessment, and treatment planning provisions of paragraphs (b) and (c) of this section with respect to dually eligible individuals. The State bases its determination on the services it requires the MCO to furnish to dually eligible enrollees.

The MCO shall take a comprehensive and collaborative approach to coordinate care for the eligible population and targeted conditions as specified by the Department through an effective care coordination program, partnerships with primary care and long-term care providers and specialists, provider and consumer participation, consumer/family outreach and education, and the ability to holistically address member's health and long-term care needs. Care coordination shall include not only the specific diagnosis but also the complexities of multiple co-morbid conditions, including behavioral health, and related issues such as the lack of social or family support.

The MCO shall offer and provide care coordination services which coordinate and monitor the care of members with specific diagnosis and/or who require high-cost or extensive services. The MCO's care coordination program shall include, at a minimum, the following:

a. identification of members who potentially meet the criteria for care management;

b. assessment of the health and long-term care conditions for members with a positive identification, to determine the need for care management;

c. notification to the member and their PCP and other providers of the member's enrollment in the MCO's care management program;

d. development and implementation of a care treatment plan for members in care management based on the assessment which includes member and PCP and long-term care provider participation in both development and implementation phases of the care treatment plan;
e. coordination of care and communication between the member, PCP, and other service providers and care coordinators; and

f. coordination with state agencies as appropriate (e.g., the Department of Mental Health Mental Retardation and Substance Abuse Services [DMHMRSAS]).

The following components should be incorporated into the MCOs care coordination program:

a. Identification

The MCO shall have mechanisms in place to identify members potentially eligible for care coordination services. These mechanisms must include an administrative data review (e.g., diagnosis, cost threshold, and/or service utilization) and may also include telephone interview; mail survey; provider/self referrals; or home visits.

b. Assessment

The MCO shall arrange for or conduct a comprehensive assessment of the member's physical, mental health and long-term care conditions to confirm the result of a positive identification and to determine the need for care management services. The goals of the assessment are to identify the recipient member's existing and/or potential health and long-term care needs and assess the member's need of care management services. Furthermore, the MCO shall provide information to the members and their provider that they have been identified as meeting the criteria for care management, including their enrollment into care management services.

c. Care coordination

Risk Stratification/Levels of Care

The MCO must develop a strategy to risk stratify members into different levels of care, based on the member's comprehensive needs assessment. The MCO's risk stratification shall consist of a minimum of the following two components:

i. Care Coordination For All Participants (Including Dual Eligibles)
   1. Access to a 24 hour/7 days a week nurse help-line;
   2. Customer service line;
   3. Offer referrals to Medicare for services and appeals when appropriate;
   4. Provide information on program options;
   5. Referral of participants to appropriate community resources in order to maximize utilization of community resources available in the participant's region; and
   6. Coordinate pre-admission screening for recipients who may need EDCD services.

ii. Expanded Care Coordination – for individuals in the EDCD waiver:
   There are two levels of Expanded Care Coordination. The levels of support were designed to enable maximum self-direction and flexibility by the EDCD Waiver

participant. The first, which is required, is considered the minimum level of Expanded Care Coordination that requires EDCD Waiver recipient participation. The second level provides additional support to EDCD Waiver participants if they choose to have this level of support.

Required MCO Care Coordination for All EDCD Participants: EDCD Waiver participants must participate in the following activities with their care coordinator:

1. Performing annual level of care re-evaluations and service plan updates to ensure necessity of home and community-based long-term care services and to identify unmet medical or social needs;
2. Coordination with social service agencies (e.g. local departments of health and social services); and
3. Monitoring of services provided;
4. Maintaining and monitoring individual service records;
5. Participating in discharge planning (to include nursing facility discharge), when appropriate, to ensure awareness of and access to community based services; and
6. Coordination with Medicare services if individual is enrolled in MCO's Medicare plan.

Optional MCO Care Coordination for EDCD participants: EDCD Waiver participants may choose to have the MCO Care Coordinator provide additional supports through the following activities:

1. Setting up appointments;
2. Setting up transportation;
3. Shepherding medical/long-term care information between providers;
4. Providing a point person for recipients and caregivers; and

Once the member has been risk-stratified, the MCO shall, a minimum:

1. Develop a person-centered care plan;
2. Implement member-level interventions;
3. Continuously monitor the progress of the participant;
4. Identify gaps between care recommended and actual care provided, and propose and implement interventions to address the gaps; and
5. Re-evaluate the member's risk level and adjust the level of care management services accordingly.

d. Care Plan

Based on the assessment, the MCO shall assure and coordinate the placement of the member into care management and development of a care plan within 90 calendar days of initial enrollment in the MCO. The care plan as defined by DMAS is developed by the MCO.

The eligible member and the member's PCP or long-term care provider must be actively involved in the development of the care plan. The designated provider is the physician who will manage and coordinate the overall care for the member. Ongoing communication regarding the status of the care plan may be accomplished between the MCO and the PCP's designee (i.e., qualified health professional). Revision to the clinical portion of the care plan should be completed in consultation with the PCP.

The MCO shall arrange or provide for professional care management services that are performed collaboratively by a team of professionals (which may include physicians, physician assistants, long-

term care providers, nurses, specialists, pediatricians, pharmacists, behavior health specialists, and/or social workers) appropriate for the member's condition and health and long-term care needs. The care plan should reflect the member's primary medical diagnosis and health condition, and co-morbidities, and the member's psychological and community support needs. At a minimum, the MCO must attempt to coordinate care with the member's care coordinator from other health systems, including behavioral health. The care plan must also include specific provisions for periodic reviews of the member's condition and appropriate updates to the plan.

e. Designation of PCP

For members with care management needs, the designated PCP is the physician who will manage and coordinate the primary and acute care for the member. If a newly enrolled member has had a previous relationship with a physician or provider who was managing their care prior to membership with the MCO, the MCO shall contact that physician or provider, if not already a MCO panel provider, and offer the opportunity to participate as a PCP, including the signing of a contract with the MCO specifying the additional expectations.

5.28.1 Care management program staffing

In response to this contract, the MCO shall identify the types of staff that will be involved in the operations of the care management program, including but not limited to: care coordinator supervisor, care coordinators, and administrative support staff. The MCO shall identify the role/functions of each care management staff member as well as the required educational requirements, clinical licensure standards certification and relevant experience with care management standards and/or activities. Furthermore, the MCO shall provide to the Department the care coordinator staff/member ratios based on the member risk stratification and different levels of care being provided to members.

5.28.2 Care management strategies

The MCO shall follow best-practice and/or evidence-based clinical guidelines when devising a member's treatment plan and coordinating the care management needs. Such guidelines may include the ten key elements of care coordination for Medicaid managed care programs from the Robert Wood Johnson Foundation's Medicaid Managed Care Program, Center for Health Care Strategies, Inc. (February) Wehr E. (2000) *Basic Elements of Care Coordination for People with Special Health Care Needs in Medicaid Managed Care.* These elements include:

1. The purpose of care coordination is to assist persons with special health care needs and their families gain access to services covered in their Medicaid managed care plans and to other services available in their communities.
2. Care coordination operates as an independent, identifiable function within a managed care organization (MCO).
3. Care coordination is structurally related to MCO systems that influence consumer access to and quality of care. At a minimum, these systems include prior authorization, quality assurance, and complaints and grievance programs.
4. Care coordination is supported by an information system dedicated to care coordination and linked to other MCO information systems (with appropriate privacy safeguards).
5. The MCO maintains policies and procedures to establish relationships between care coordinators and providers.
6. The MCO maintains policies and procedures to establish working relationships between relevant MCO personnel and programs and a range of public and voluntary programs, services, agencies, and systems that may also serve MCO enrollees.

7. Care coordination requires a written plan of care based on a comprehensive assessment of the goals, capacities, and medical condition of a consumer and the needs and goals of family caretakers. The plan includes both managed care and community services.
8. Care coordination includes monitoring to assure that services are received, to identify problems in the quality of care, to reassess and review care plans, and to advocate on behalf of enrollees and family caretakers.
9. MCO policies and procedures are designed to make care coordination readily accessible.
10. Care coordination is furnished by individuals and teams with appropriate experience and training. Standards for care and case loads are established.

5.28.3 Information technology system for care management

The MCO's information technology system for its care management program shall maximize the opportunity for communication between the plan, PCP, the patient, other service providers and care coordinators. The MCO shall have an integrated database that allows MCO staff that may be contacted by a member in care management to have immediate access to and review of the most recent information within the MCO's information systems relevant to the case. The integrated database may include the following: administrative data, call center care management notes, and PCP notes. For example, managed care plan member services staff must have access to a member's care management notes and recent inpatient or emergency department utilization if contacted by that member. The information technology system must also have the capability to share relevant information (i.e., utilization reports, care treatment plans, etc.) with the member, the PCP, and other service providers and care coordinators.

5.29 Enrollee Education Program

The MCO shall develop, administer, implement, monitor, and evaluate a program to promote health education services for its new and continuing VALTC enrollees, as indicated below. For the purposes of this contract, no program information document shall be used unless it achieves a Flesch total readability score of (40) or better, and set at a 12-point font. (These requirements shall not apply to language that is mandated by Federal or State laws, regulations or agencies.) The MCO shall maintain a written plan for health education and prevention which is based on the needs of its enrollees. The MCO shall submit, in response to this contract and annually thereafter a health education and prevention plan to the Department. At a minimum, the education plan shall describe topics to be delivered via printed materials, audiovisual or face-to-face communications and the time frames for distribution. Any changes to the education plan must be approved by the Department prior to implementation.

The MCO shall be responsible for developing and maintaining enrollee education programs designed to provide the enrollee with clear, concise, and accurate information about the MCO's health plan. Additionally, the MCO shall provide the Department annually with a copy of all member health education materials, including any newsletters sent to its members.

5.30 Provider Network Composition and Access to Care Standards

In accordance with 42 CFR §438.206, the MCO shall maintain and monitor a network of appropriate providers that is supported by written contracts and is sufficient to provide adequate access to all services covered under this contract. The MCO provider network for the VALTC program must meet the qualifications as set forth in the 1915(b) and 1915(c) waiver applications. Contractors shall utilize their individual credentialing and recredentialing standards in network development and maintenance.

Network provider composition standards set forth in this contract are not the minimum standards for network development for entry into new or existing managed markets. These standards shall be

considered as operational guidelines. The Department shall be the sole determiner of MCO network sufficiency.

5.30.1 Network provider composition

The MCO shall be solely responsible for arranging for and administering covered services to enrolled enrollees and shall ensure that its delivery system shall provide available, accessible and adequate numbers of facilities, locations and personnel for the provision of covered services. In establishing and maintaining the network, the MCO shall consider all of the following:

a. the anticipated VALTC enrollment;

b. the expected utilization of services, taking into consideration the characteristics and health and long-term care needs of the anticipated Medicaid population to be served;

c. the numbers and types (in terms of training and experience, and specialization) of providers required to furnish the contracted services;

d. the numbers of network providers not accepting new Medicaid patients;

e. the geographic location of providers and enrollees, considering distance, travel time, and the means of transportation ordinarily used by Medicaid enrollees; and

f. whether the location provides physical access for enrollees with disabilities.

The MCO shall include in its network or otherwise arrange care or consult with providers specializing in geriatric services, dealing with persons with disabilities, and mental health for its members. The MCO is encouraged to develop and maintain a list of referral sources which includes community agencies, State agencies, "safety net" providers, teaching institutions and facilities that are needed to assure that the enrollees are able to access and receive the full continuum of treatment and rehabilitative medical and outpatient mental health services and supports needed.

The MCO shall notify the Department within thirty (30) business days of any changes to a network provider contract made by the MCO, a subcontractor, or network provider regarding termination, pending termination, or pending modification in the subcontractor's or network provider's terms that could reduce enrollee access to care. The MCO shall notify the Department where it experiences difficulty in contracting or re-contracting with hospitals or hospital systems. This written notice must occur in advance of the formal notification of hospital's termination from the MCO's network.

Any physician who provides inpatient services to the MCO's enrollees shall have admitting and treatment privileges in a minimum of one general acute care hospital that is in the MCO's network and is located within the contracted service area.

5.30.2 Provider enrollment into Medicaid

The MCO shall make best effort that as part of its credentialing process to encourage all providers, including ancillary providers, (i.e. vision, pharmacy, etc.), to apply for enrollment in the Medicaid program. The MCO shall be required to have a NPI or an Administrative Provider Identification Number (APIN) number.

5.30.3 Network provider licensing and certification standards

Each MCO must have the ability to determine whether physicians and other health care and long-term care professionals are licensed by the State and have received proper certification or training to perform medical and clinical services agreed to under this contract. The MCO's standards for licensure and certification shall be included in its participating provider network contracts with its network providers which must be secured by current subcontracts or employment contracts.

5.30.4 Specialist services

The MCO shall maintain in its network and in its referral listing a number of specialists in the following specialties which is adequate to provide covered services to its VALTC enrollees:

Audiology
Allergy/Immunology
Anesthesiology
Cardiology
Colon/Rectal Surgery
Dermatology
Endocrinology
Gastroenterology
General Surgery
Genetics Metabolism
Geriatrics
Hematology
Infectious Diseases
Internal Medicine
Neonatal/Perinatal Medicine
Nephrology
Neurological Surgery
Neurology
Oncology
Ophthalmology
Oral Surgery
Orthopedic Surgery
Otolaryngology
Periodontists
Physical Medicine/Rehabilitation/Physiatrist
Plastic Surgery
Pulmonology Preventive Medicine
Psychiatry
Psychology
Radiology
Rheumatology
Thoracic Surgery
Urology

5.30.5 Inpatient hospital access

The MCO shall maintain in its network a sufficient number of inpatient hospital facilities which is adequate to provide covered services to its enrollees. The MCO shall notify the Department within fifteen (15) calendar days of any changes to its contracts with hospitals if those changes impact the scope of covered services, the number of individuals covered and/or the units of service covered.

5.30.6 Policy of nondiscrimination

The MCO shall ensure that its providers provide services to enrollees under this contract in the same manner as they provide those services to all non-Medicaid enrollees. Additionally, in accordance with 42 CFR §438.206, the MCO shall ensure that its network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service, if the provider serves only Medicaid enrollees.

5.30.7 Waiver services providers

The MCO shall enter into provider contracts for the provision or administration of EDCD Waiver covered services. The MCO shall ensure that waiver service providers in their networks meet, at a minimum, DMAS provider qualifications and have received proper certification and/or training to perform the

specific waiver services for which they are contracted. The MCO shall be responsible for arranging for and administering covered waiver services to enrolled participants and must ensure that the delivery system will provide available, accessible, and adequate coverage of waiver services. The Contractors shall have written policies and procedures for credentialing/recredentialing, and shall perform a scheduled review on all providers to assure that the providers and personnel under contract are qualified to perform the covered waiver services.

Provider qualification requirements for services provided under the EDCD waiver may be found at the following regulatory and DMAS manual cites:

a. Adult Day Health Care
   Regulation: (12-30-120-940(B)); (12-30-120-940(C)) and 12 VAC 40-60-10 et seq (Licensing regulations)
   http://leg1.state.va.us/cgi-bin/legp504.exe?000+reg+12VAC30-120-940
   Manual: (Chapter II, Pages 11-17):
   http://websrvr.dmas.virginia.gov/manuals/edcd/EDCD_chapter_2.pdf

b. Agency Directed Personal Care
   Regulation: (12-30-120-950(D))
   http://leg1.state.va.us/cgi-bin/legp504.exe?000+reg+12VAC30-120-950
   Manual: (Chapter II, Pages 8-11)
   http://websrvr.dmas.virginia.gov/manuals/edcd/EDCD_chapter_2.pdf

c. Agency Directed Respite Care
   Regulation: (12-30-120-960(D))
   http://leg1.state.va.us/cgi-bin/legp504.exe?000+reg+12VAC30-120-960
   Manual: (Chapter II, Pages 8-11)
   http://websrvr.dmas.virginia.gov/manuals/edcd/EDCD_chapter_2.pdf

d. Personal Emergency Response System (PERS)
   Regulation: (12-30-120-970(D)) and (12-30-120-970(E))
   http://leg1.state.va.us/cgi-bin/legp504.exe?000+reg+12VAC30-120-970
   Manual: (Chapter II, Pages 17-19)
   http://websrvr.dmas.virginia.gov/manuals/edcd/EDCD_chapter_2.pdf

e. Environmental Modification
   Regulation: (12-30-120-758(D)
   http://www.townhall.state.va.us/L/ViewXML.cfm?textid=1628
   Manual: not yet available

f. Assistive Technology
   Regulation: (12-30-120-762(D)
   http://www.townhall.state.va.us/L/ViewXML.cfm?textid=1628
   Manual: not yet available

g. Consumer Directed Services (Service Facilitation)
   Regulation: (12-30-120-980(D))
   http://leg1.state.va.us/cgi-bin/legp504.exe?000+reg+12VAC30-120-980
   Manual: (Chapter II, Pages 19-21)
   http://websrvr.dmas.virginia.gov/manuals/edcd/EDCD_chapter_2.pdf

h. Consumer Directed Services (Personal Care Aide)
Regulation: (12-30-120-980(D)(10)
http://leg1.state.va.us/cgi-bin/legp504.exe?000+reg+12VAC30-120-980
Manual: (Chapter II, Pages 21-22)
http://websrvr.dmas.virginia.gov/manuals/edcd/EDCD_chapter_2.pdf

The MCO shall be required to ensure the completion of criminal records checks as outlined in state regulations for the following positions:

i. Personal Assistants - 12VAC30-120-950(D)(2)
ii. Respite Care Assistants - 12VAC30-120-960(D)(2)
iii. Adult Day Health Care Workers - 22VAC40-90-40 through 22VAC40-90-60
iv. Registered Nurse - 12VAC30-120-950(D)(2)
v. Licensed Practical Nurse - 12VAC30-120-950(D)(2)

The scope of the investigation includes a Virginia State Police Criminal History Records Check. All agency providers licensed by the Virginia Department of Health must demonstrate that criminal records checks have been completed as a part of the annual licensing process. All agency providers exempt from licensing pursuant to § 32.1-162.8 must demonstrate that criminal records checks have been completed as a part of the Quality Management Review process conducted by DMAS. All agency providers must also demonstrate the completion of criminal records checks as a part of the enrollment process with the MCO. For consumer- directed services, the MCO shall be responsible for conducting criminal records checks.

MCOs shall request the criminal background checks to the Virginia State Police prior to the start of employment with additional supervision provided to the employee until the records check results are received, typically within 30 days.

5.30.8 Provider file

The MCO shall submit to the enrollment broker and the Department a complete provider file. The file shall be a separate provider file designated specifically for the VALTC program and shall not be the provider file sent to the enrollment broker for other Medicaid managed care programs. The file shall be in a Department approved electronic format. The provider file shall be submitted 120 days prior to the effective date of the contract. An updated file with all of the changes to the network shall be submitted monthly thereafter to the Enrollment Broker. The MCO shall submit to the Department a complete provider file quarterly. Appendix H details the required reporting data elements. Additional required elements to be included in this report may be identified by the Department.

5.30.9 Enrollee-to-PCP ratios

As a means of measuring accessibility, the MCO must have at least one (1) full-time equivalent (FTE) PCP, regardless of specialty type, for every 1,500 Medicaid enrollees. No PCP may be assigned enrollees in excess of these limits, except where mid-level practitioners are used to support the PCP's practice.

Each contract between the MCO and any of its network providers who are willing to act as a PCP must indicate the number of open panel slots available to the MCO for enrollees under this contract.

This standard refers to the total VALTC enrollees under enrollment by the MCO as identified in this contract. If necessary to meet or maintain appointment availability standards set forth in this contract, the MCO shall decrease the number of enrollees assigned to a PCP. When specialists act as PCPs, the duties they perform must be within the scope of their specialist's license.

5.30.10 Twenty-four hour coverage

The MCO shall maintain adequate provider network coverage to serve the entire eligible VALTC populations in geographically accessible locations within the region twenty-four (24) hours per day, seven (7) days a week. The MCO shall make arrangements to refer patients seeking care after regular business hours to a covering physician or shall direct the enrollee to go to the emergency room when a covering physician is not available. Such referrals may be made via a recorded message.

In accordance with the Code of Virginia § 38.2-4312.3, as amended, the MCO shall maintain after-hours telephone service, staffed by appropriate medical personnel, which includes access to a physician on call, a primary care physician, or a member of a physician group for the purpose of rendering medical advice, determining the need for emergency and other after-hours services, authorizing care, and verifying enrollee enrollment with the MCO.

5.30.11 Travel time and distance

a. Travel Time Standard

   The MCO shall ensure that each enrollee shall have a choice of at least two (2) PCPs located within no more than thirty (30) minutes travel time from any enrollee in urban areas unless the MCO has a Department-approved alternative time standard. Travel time shall be determined based on driving during normal traffic conditions (i.e., not during commuting hours). The MCO shall ensure that each enrollee shall have a choice of at least two (2) PCPs located within no more than sixty (60) minutes travel time from any enrollee in rural areas unless the MCO has a Department-approved alternative time standard. The MCO shall ensure that obstetrical services are available within no more than forty-five (45) minutes travel time from any pregnant enrollee in rural areas unless the MCO has a Department approved alternative time standard.

b. Travel Distance Standard

   The MCO shall ensure that each enrollee shall have a choice of at least two (2) PCPs located within no more than a fifteen (15) mile radius in urban areas and thirty (30) miles in rural areas unless the MCO has a Department-approved alternative distance standard. The MCO must ensure that an enrollee is not required to travel in excess of thirty (30) miles in an urban area and sixty (60) miles in a rural area to receive services from specialists, hospitals, special hospitals, psychiatric hospitals, diagnostic and therapeutic services, and physicians, or other necessary providers, unless the enrollee so chooses. An exception to this standard may be granted when the MCO has established, through utilization data provided to the Department, that a normal pattern for securing health care services within an area falls beyond the prescribed travel distance or the MCO, and its PCPs are providing a higher skill level or specialty of service that is unavailable within the service area such as treatment of cancer, burns, or cardiac diseases.

5.30.12 Appointment standards

The MCO shall arrange to provide care according to each of the following appointment standards:

a. Appointments for emergency services shall be made available immediately upon the enrollee's request.

b. Appointments for an urgent medical condition shall be made within twenty-four (24) hours of the enrollee's request.

c. Appointments for routine, primary care services shall be made within thirty (30) calendar days of the enrollee's request. This standard does not apply to appointments for routine physical examinations, for regularly scheduled visits to monitor a chronic medical condition if the schedule calls for visits less frequently than once every thirty (30) days, or for routine specialty services like dermatology, allergy care, etc.

For maternity care, the MCO shall be able to provide initial prenatal care appointments for pregnant enrollees as follows:

a. First trimester - within fourteen (14) calendar days of request

b. Second trimester - within seven (7) calendar days of request

c. Third trimester - within three (3) business days of request

Appointments shall be scheduled for high-risk pregnancies within three (3) business days of identification of high risk to the MCO or maternity provider, or immediately if an emergency exists.

5.30.13 Emergency services coverage

The MCO shall ensure that all emergency services are available twenty-four (24) hours a day, seven (7) days a week, either in the MCO's own facilities or through arrangements with other subcontractors. The MCO shall designate emergency sites that are as conveniently located as possible for after-hours emergency care.

The MCO shall negotiate provider contracts with emergency care providers to ensure prompt and appropriate payment for emergency services. Such network provider contracts shall provide for the following:

a. The process for determining a true and actual emergency;
b. The requirements and procedures for contacting the MCO before administering urgent or routine care; and

c. Contracts between the MCO and the provider regarding indemnification, malpractice, or other legal liabilities, which would apply to the MCO or the provider in the absence of such a contract.

5.30.14 Medical help line access standards

The MCO shall provide a toll-free telephone line twenty-four (24) hours a day, seven (7) days a week, staffed by medical professionals to assist enrollees. Additionally, the MCO shall advise the Department prior to signing the original contract, upon revision or on request the process it utilizes to meet this requirement.

The MCO shall have mechanisms in place to promote the Medical Helpline to its VALTC members. Mechanisms must include ways to distribute periodic reminders of the Helpline, and cannot be exclusive to information only being provided in the plan handbook or Explanation of Benefits.

5.30.15 Assurances that access standards are being met

The MCO shall establish a system to monitor its provider network to ensure that the access standards set forth in this contract are met, must monitor regularly to determine compliance, taking corrective action when there is a failure to comply, and must be prepared to demonstrate to the Department that these access standards have been met.

5.31 Provider Relations

5.31.1 Provider enrollment

The MCO shall provide adequate resources to support a provider relations function that will effectively communicate with existing and potential network providers. The MCO shall give each network provider explicit instructions about the MCO's provider enrollment process, including enrollment forms, brochures, enrollment packets, provider manuals, and participating provider contracts. The MCO shall provide this information to potential network providers upon request. The MCO's network provider contract shall comply with the terms set forth in Appendix J.

The MCO shall not require as a condition of participation/ contracting with physicians, etc. in their VALTC Medicaid network to also participate in the MCO's commercial managed care network. However, this provision would not preclude a MCO from requiring their commercial network providers to participate in their VALTC Medicaid provider network.

5.31.2 Anti-discrimination

Pursuant to Section 1932 (b)(7) of the SSA, the MCO shall not discriminate with respect to participation, reimbursement, or indemnification as to any provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification. Additionally, consistent with 42 CFR 438.214(c), provider selection policies and procedures must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. If the MCO declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision. [42CFR438.12(a)]

This section shall not be construed to prohibit the MCO from including providers only to the extent necessary to meet the needs of the organization's enrollees; or from using different reimbursement amounts; or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the MCO. [42CFR438.12(b)]

5.31.3 Provider education

The MCO shall ensure that all providers receive proper education and training regarding the VALTC managed care program to comply with this contract and all applicable Federal and State requirements. The MCO shall offer educational and training programs that cover topics or issues including, but not limited to, the following:

a. All VALTC covered services, carved-out and enhanced services, policies, procedures, and any modifications to these items;

b. VALTC eligibility standards, eligibility verification, and benefits;

c. The role of the enrollment broker regarding enrollment and disenrollment;

d. Special needs of enrollees in general that may affect access to and delivery of services, to include, at a minimum, transportation needs;

e. The rights and responsibilities of the enrollees;

f. Grievance and appeals procedures;

g. Procedures for reporting fraud and abuse;

h. References to Medicaid manuals, memoranda, and other related documents;

i. Payment policies and procedures;

j. Billing instructions which are in compliance with the Department's encounter data submission requirements; and,

k. Marketing practice guidelines and the responsibility of the provider when representing the MCO.

The MCO shall conduct education seminars and/or individual training for all providers within sixty (60) calendar days after the MCO places a newly enrolled provider on active status. The MCO shall also conduct ongoing training and education when deemed necessary by the MCO or the Department.

5.31.4 Provider payment

In accordance with Section 1932(f) of the Social Security Act (42 U.S.C. §1396a-2), the MCO shall pay all in-and out-of-network providers on a timely basis, consistent with the claims payment procedure described in 42 C.F.R. § 447.45, Section 1902 (a)(37), upon receipt of all clean claims for covered services rendered to covered enrollees who are enrolled with the MCO. 42 C.F.R. § 447.45 defines timely processing of claims as:

a. Adjudication (pay or deny) of ninety per cent (90%) of all clean Virginia Medicaid claims within thirty (30) calendar days of the date of receipt.

b. Adjudication (pay or deny) of ninety-nine per cent (99%) of all Virginia Medicaid clean claims within ninety (90) calendar days of the date of receipt.

c. Adjudication (pay or deny) all other claims within twelve (12) months of the date of receipt. (See 42 C.F.R. §447.45 for timeframe exceptions.) This requirement shall not apply to network providers who are not paid by the MCO on a fee-for-service basis and will not override any existing negotiated payment scheduled between the MCO and its providers.

The MCO shall notify the Department 45 days in advance of any proposal to modify claims operations and processing that shall include relocation of any claims processing operations. Any expenses incurred by the Department or its contractors to adapt to the MCO's claims processing operational changes (including but not limited to costs for site visits) shall be borne by the MCO.

The MCO shall make available to providers an electronic means of submitting claims. In addition, the MCO shall make every effort to assure at least fifty (50%) percent of claims received from providers (excluding long-term care providers) are submitted electronically.

The MCO shall pay interest charges on claims in compliance with requirements set forth in § 38.2-4306.1 of the Code of Virginia. Specifically, interest upon the claim proceeds paid to the subscriber, claimant, or assignee entitled thereto shall be computed daily at the legal rate of interest from the date of thirty calendar days from the MCO's receipt of "proof of loss" to the date of claim payment. "Proof of loss" means the date on which the MCO has received all necessary documentation reasonably required by the MCO to make a determination of benefit coverage. This requirement does not apply to claims for which payment has been or will be made directly to health care providers pursuant to a negotiated reimbursement arrangement requiring uniform or periodic interim payments to be applied against the managed care organization's obligation on such claims.

To the extent the Governor and/or General Assembly implement any rate adjustments for Medicaid services/providers and as identified by the Department, and these rate adjustments are incorporated into the VALTC capitation payment rates during the contract period, the MCO shall be required to increase its reimbursement at the same percentage as Medicaid's increase as reflected in the revised fee-for-service fees under the Medicaid fee schedule, beginning on the effective date of the rate adjustment, unless otherwise agreed to by the Department. The Department shall make every reasonable effort to provide at least 30 days advance notice of such increases. The MCO shall provide written notice to providers in a format determined by the MCO advising of the rate adjustment and when it shall be effective. A copy of such notification shall be provided to the Department before the MCO's mailing of such notice.

The MCO shall establish an internal grievance procedure by which providers under contract may challenge the MCO's decisions including, but not limited to, the denial of payment for services.

5.31.5 Provider disenrollment

The MCO shall have in place written policies and procedures which are filed at the time of initial contract signature with DMAS related to provider disenrollment.

For PCPs, these policies and procedures shall include, but are not limited to, the following:

a. Procedures to provide a good faith effort to give written notice of termination of a contracted provider within 15 days after receipt or issuance of the termination notice to each enrollee who received his or her primary care from the terminated provider. [42CFR438.10(f)(5)]

b. Procedures to provide a good faith effort to transition PCP panel enrollees to new PCPs at least thirty (30) calendar days prior to the effective date of provider disenrollment;

c. Procedures for the reassessment of the provider network to ensure it meets access standards established in its contract;

d. Procedures for notifying the Department within the time frames set forth in this contract; and

e. Procedures for temporary coverage in the case of unexpected PCP absence (e.g., due to death or illness).

For other network providers, these policies and procedures must address, at a minimum:

a. Procedures to provide a good faith effort to give written notice of termination of a contracted provider within 15 days after receipt or issuance of the termination notice to each enrollee who received care on a regular basis by the terminated provider. [42CFR438.10(f)(5)]

b. Procedures for notifying enrollees at least thirty (30) calendar days before the effective date of provider disenrollment;

c. Procedures for the reassessment of the provider network to ensure it meets access standards established in this contract;

d. Procedures for notifying the Department within the time frames set forth in this contract; and

e. Procedures for temporary coverage in case of unexpected provider absence (e.g., due to death or illness).

5.31.6 Ineligible provider or administrative entities

The MCO shall, upon obtaining information or receiving information from the Department or from another verifiable source, exclude from participation in the MCO's plan for this contract all provider or administrative entities which could be included in any of the following categories (references to the Act in this Section refer to the Social Security Act):

a. Entities which could be excluded under § 1128(b)(8), as amended, of the Social Security Act are entities in which a person who is an officer, director, or agent or managing employee of the entity, or a person who has direct or indirect ownership or controlling interest of five (5) percent or more in the entity has:
    i. Been convicted of any of the following crimes:
        1. Program related crimes, i.e., any criminal offense related to the delivery of an item or service under any Medicare, Medicaid, or other State health care program (as provided in § 1128(a)(1) of the Act, as amended);
        2. Patient abuse, i.e., a criminal offense relating to abuse or neglect of a patient in connection with the delivery of a health care item or service (as provided in § 1128(a)(2) of the Act, as amended);
        3. Fraud, i.e., a State or Federal crime involving fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct in connection with the delivery of health care or involving an act or omission in a program operated by or financed in whole or part by Federal, State or local government (as provided in § 1128(b)(1) of the Act, as amended);
        4. Obstruction of an investigation, i.e., conviction under State or Federal law of interference or obstruction of any investigation into any criminal offense described in subsections of a. b. or c (as provided in § 1128(b)(2) of the Act, as amended); or
        5. Offenses relating to controlled substances, i.e., conviction of a State or Federal crime relating to the manufacture, distribution, prescription or dispensing of a controlled substance (as provided in § 1128(b)(3) of the Act, as amended);
    ii. Been excluded from participation in Medicare or a State health care program;
    iii. Been assessed a civil monetary penalty under Section 1128A of the Social Security Act [42 U.S.C. § 1320a-7(a)-(f)]; or
    (Civil monetary penalties can be imposed on an individual provider, as well as on provider organizations, agencies, or other entities, by the HHS Office of Inspector General and may be imposed in the event of false or fraudulent submittal of claims for payment and certain other violations of payment practice standards.)
    iv. Been debarred, suspended, or otherwise excluded from participation in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued pursuant to Executive Order No. 12549 and 45 CFR Part 76 or under guidelines implementing such an order or is an

affiliate (as defined in such Act) of a person described in clause (a).

The MCO shall immediately notify the Department of any action taken by the MCO to exclude, based on the provisions of this section, an entity currently participating.

b. Entities which have a direct or indirect substantial contractual relationship with an individual or entity described in Paragraph 1, above. A substantial contractual relationship is defined as any contractual relationship which provides for one or more of the following services:
   i. The administration, management, or provision of medical services;
   ii. The establishment of policies pertaining to the administration, management, or provision of medical services; or
   iii. The provision of operational support for the administration, management, or provision of medical services.

   The MCO attests by responding to this contract that it excludes from participation in the contract activities all entities which could be included in the categories listed in b. i. through iii. above.

5.31.7 Physician incentive plan

In accordance with 42 C.F.R. § 434.70, the MCO shall comply with 42 C.F.R. §§ 417.479(a) through (g) as amended, specifying the requirements for physician incentive plans. If the MCO enters into subcontracting arrangements, it shall comply with 42 CFR § 417.479(i), as amended. If a physician financial arrangement is determined by the Department to potentially avoid costs by limiting referral specialty care for enrollees, the MCO must demonstrate to the Department that all medically necessary referrals were authorized during the contract period. The MCO is prohibited from making any payment under a PIP as an inducement to limit or reduce medically necessary services to an individual. The Physician Incentive Plan should be submitted annually to the Department using the CMS established form.

The MCO shall report annually whether services not furnished by physician/group are covered by PIP or incentive arrangement that includes withhold, bonus, capitation, and percent of withhold or bonus, if applicable.

5.31.8 Protection of enrollee-provider communications

The MCO shall not prohibit or restrict a health care professional from advising a enrollee about his or her health status, medical care, or treatment, regardless of whether benefits for such are provided under the contract, if the provider is acting within the lawful scope of practice as described in Section 4704 (b)(3) of Public Law 105-33.

5.31.9 Protected health information

To the extent that the MCO uses one or more providers to render services under this contract, and such providers receive or have access to protected health information (PHI), each such provider shall sign a Business Associate Contract with the MCO that complies with HIPAA. The MCO shall ensure that any providers to whom it provides PHI received from the Department (or created or received by The MCO on behalf of the Department) agree in writing to the same restrictions, terms, and conditions relating to PHI that apply to the MCO in this contract.

5.31.10 Provider appeals

a. Appeals to the MCO

The MCO shall have a reconsideration and appeals process in place congruent with current national quality standards available to providers who wish to challenge adverse decisions. This process must assure that appropriate decisions are made as promptly as possible.

b. Appeals to DMAS

If a provider has rendered services to a client enrolled with the MCO and has either been denied reimbursement for the services or has received reduced reimbursement, that provider can request an appeal of the denied or reduced reimbursement. Before appealing to the Department, the MCO's providers and sub-contractors must first exhaust all MCO reconsideration and appeal processes. If DMAS specifies an additional DMAS reconsideration process, that reconsideration process shall also be a prerequisite to filing a provider appeal. All requests for appeals to DMAS shall be filed with DMAS in writing and within 30 days of the receipt of the MCO's final appeal decision. Requests for appeal shall be addressed to the DMAS Appeals Division, 600 East Broad Street, 11th Floor, Richmond, VA 23219. Requests for appeals are considered filed when they are date-stamped into the Appeals Division.

Provider appeals to DMAS shall be conducted in accordance with the requirements set forth in 12VAC30-20-500 et. seq. There are two levels of administrative appeal: (i) the informal first-level appeal, and (ii) the second-level formal administrative appeal.

i. Informal (first-level) appeal - Providers appealing a MCO's decision shall file a written notice of informal appeal with the DMAS Appeals Division within 30 days of the provider's receipt of the MCO's final appeals decision. The provider's notice of informal appeal shall identify the issues being appealed. Failure to file a written notice of informal appeal within 30 days of receipt of the MCO's final appeals decision shall result in dismissal of the appeal.

The MCO shall file a written case summary with the DMAS Appeals Division within 30 days of the filing of the provider's notice of informal appeal. The MCO shall mail a complete copy of the case summary to the Department's VALTC Contract Monitor and to the provider on the same day that the case summary is filed with the DMAS Appeals Division. The case summary shall address each adjustment, patient, service date, or other disputed matter and shall state the MCO's position for each adjustment, patient, service date, or other disputed matter. The case summary shall contain the factual basis for each adjustment, patient, service date, or other disputed matter and any other information, authority, or documentation the MCO relied upon in taking its action or making its decision. Failure by the MCO to file a written case summary with the Appeals Division in the detail specified within 30 days of the filing of the provider's notice of informal appeal shall result in dismissal in favor of the provider on those issues not addressed in the detail specified. The MCO shall be responsible for reimbursement to DMAS for any financial loss incurred due to a dismissal based upon the MCO's failure to provide a sufficient case summary in a timely manner.

The informal first-level appeal is before an informal appeals agent employed by the Department. The DMAS informal appeals agent shall conduct the conference within 90 days from the filing of the notice of informal appeal. If the MCO and the provider and the

DMAS informal appeal agent agree, the conference may be conducted by way of written submissions. If the conference is conducted by way of written submissions, the DMAS informal appeals agent shall specify the time within which the parties may file written submissions, not to exceed 90 days from the filing of the notice of informal appeal. Only written submissions filed within the time specified by the informal appeals agent shall be considered.

If an informal conference is conducted, the MCO shall be required to attend and defend the MCO's decision at the informal conference with the provider before a DMAS Informal Appeals Agent. If the MCO's decision was based in whole or part upon a medical determination such as "medical necessity or appropriateness" the MCO shall provide sufficiently qualified medical personnel to attend the conference and defend the decision being appealed. The conference may be recorded for the convenience of the DMAS informal appeals agent. Since the conference is not an adversarial or evidentiary proceeding, recordings shall not be made part of the administrative record and shall not be made available to anyone other than the DMAS informal appeals agent. The MCO bears responsibility for its own travel and expenses to fulfill its obligation to attend the conference.

Upon completion of the conference, the DMAS informal appeals agent shall specify the time within which the provider may file additional documentation or information, if any, not to exceed 30 days. Only documentation or information filed within the time specified by the DMAS informal appeals agent shall be considered.

The informal appeal decision shall be issued within 180 days of receipt of the notice of informal appeal. Providers have the right to appeal the DMAS informal first-level appeal decision in accordance with 12VAC30-20-560, as a formal appeal.

ii. Formal (second-level) appeal - Any provider appealing a DMAS informal appeal decision shall file a written notice of formal appeal with the DMAS Appeals Division within 30 days of the provider's receipt of the DMAS informal appeal decision. The notice of formal appeal shall identify the issues being appealed. Failure to file a written notice of formal appeal within 30 days of receipt of the informal appeal decision shall result in dismissal of the appeal.

At the formal appeal level, an evidentiary hearing is held before a hearing officer appointed by the Supreme Court of Virginia, and an administrative hearing representative employed by the Department helps to present the Department's position. The Supreme Court hearing officer writes a recommended decision for use by the Director of the Department in issuing the final agency decision.

The MCO and the provider shall exchange and file with the hearing officer all documentary evidence on which the MCO or the provider relies within 21 days of the filing of the notice of formal appeal. Only documents filed within 21 days of the filing of the notice of formal appeal shall be considered. The MCO and the provider shall file any objections to the admissibility of documentary evidence within seven days of the filing of the documentary evidence. Only objections filed within seven days of the filing of the documentary evidence shall be considered. The hearing officer shall rule on any objections within seven days of the filing of the objections.

The hearing officer shall conduct the hearing within 45 days from the filing of the notice of formal appeal.

Hearings shall be transcribed by a court reporter retained by DMAS.
Upon completion of the hearing, the MCO and the provider shall have 30 days to exchange and file with the hearing officer an opening brief. Only opening briefs filed within 30 days after the hearing shall be considered. The MCO and the provider shall have 10 days to exchange and file with the hearing officer a reply brief after the opening brief has been filed. Only reply briefs filed within 10 days after the opening brief has been filed shall be considered.

The hearing officer shall submit a recommended decision to the DMAS director with a copy to the provider within 120 days of receipt of the formal appeal request. If the hearing officer does not submit a recommended decision within 120 days, then DMAS shall give written notice to the hearing officer and the Executive Secretary of the Supreme Court that a recommended decision is due.

Upon receipt of the hearing officer's recommended decision, the DMAS director shall notify the MCO and the provider in writing that any written exceptions to the hearing officer's recommended decision shall be filed within 30 days of receipt of the DMAS director's letter. Only exceptions filed within 30 days of receipt of the DMAS director's letter shall be considered. The DMAS director shall issue the final agency case decision within 60 days of receipt of the hearing officer's recommended decision.

At the formal level, the MCO assists the Department's staff counsel in preparing the case summary and acts as a witness at a hearing before a hearing officer as appointed by the Virginia Supreme Court.

The MCO shall comply with all State and Federal laws, regulations, and policies regarding content and timeframes for appeal summaries.

The MCO shall attend and defend the MCO's decisions at all appeal hearing or conferences, whether informal or formal, or whether in person or by telephone, or as deemed necessary by the DMAS Appeals Division. MCO travel or telephone expenses in relation to appeal activities shall be borne by the MCO. Failure to attend or defend the MCO's decisions at all appeal hearings or conferences shall result in the MCO being liable for any costs that DMAS incurs as a result of the MCO's non compliance. The MCO shall supply the necessary expertise, including medical expertise where DMAS deems necessary in the presentation of the case, to defend its actions and shall assist the formal appeals representative in the preparation of post-hearing matters leading to the Final Agency Decision.

The final agency decision can be appealed to court for judicial review of the record. Therefore, part of the formal administrative appeal function is to maintain an accurate and complete copy of the record of the administrative proceeding, including the decision, documentary evidence, motions, briefs, exceptions, as well as the transcript of the hearing. The first level of court review is Circuit Court, then the Virginia Court of Appeals, and then by petition to the Virginia Supreme Court.

c. Provider Appeals: State-Operated Facilities

The following procedures shall be available to state-operated providers when DMAS takes adverse action which includes termination or suspension of the provider contract and denial of payment for services rendered. State-operated provider means a provider of Medicaid services that is enrolled in the Medicaid program and operated by the Commonwealth of Virginia.

A state-operated provider has the right to request a reconsideration of any issue that would be otherwise administratively appealable under the State Plan by a non-state operated provider. This is the sole procedure available to state-operated providers.

The reconsideration process shall consist of three phases: an informal review by the Division Director, a further review by the DMAS Agency Director, and a Secretarial review. First, the state-operated provider must submit to the appropriate DMAS Division Director written information specifying the nature of the dispute and the relief sought. This request must be received by DMAS within 30 calendar days after the provider receives a Notice of Program Reimbursement (NPR), notice of proposed action, findings letter, or other DMAS notice giving rise to a dispute. If a reimbursement adjustment is sought, the written information must include the nature of the adjustment sought, the amount of the adjustment sought and the reason(s) for seeking the adjustment. The Division Director or his/her designee will review this information, requesting additional information as necessary. If either party so requests, an informal meeting may be arranged to discuss a resolution.

Any designee shall then recommend to the Division Director whether relief is appropriate in accordance with applicable laws and regulations. The Division Director shall consider any recommendation of his/her designee and render a decision.
The second step permits a state-operated provider to request, within 30 days after receipt of the Division Director's decision, that the DMAS Agency Director or his/her designee review the Decision of the Division Director. The DMAS Agency Director has the authority to take whatever measures he/she deems appropriate to resolve the dispute.

The third step, where the preceding steps do not resolve the dispute to the satisfaction of the state-operated provider, permits the provider to request, within 30 days after receipt of the DMAS Agency Director's Decision, that the DMAS Agency Director refer the matter to the Secretary of Health and Human Resources and any other Cabinet Secretary, as appropriate. Any determination by such Secretary or Secretaries shall be final.

d. VALTC Contract Disputes

Contract negotiations, disputes between MCO and subcontractor, or other MCO actions are not subject to review through the DMAS Appeals Division.

e. Repayment Of Identified Overpayments

Pursuant to § 32.1-325.1 of the *Code of Virginia*, DMAS is required to collect identified overpayments. Repayment must be made upon demand unless a repayment schedule is agreed to by DMAS. When lump sum cash payment is not made, interest shall be added on the declining balance at the statutory rate, pursuant to the *Code of Virginia*, § 32.1-313.1. Repayment and interest will not apply pending the administrative appeal. Repayment schedules must ensure full repayment within 12 months unless the provider demonstrates, to the satisfaction of DMAS, a financial hardship warranting extended repayment terms.

5.31.11 Provider inquiry performance standards

The MCO shall answer telephonic provider inquiries, including requests for referrals and prior-authorizations with a monthly average speed of answer (ASA) of less than two (2) minutes. Provider call abandonment rates shall average less than 10% each month. The Contractor will provide a monthly report of these measures to include total call volume, wait time in seconds, and abandonment percentage rate to the Department.

The MCO's report details shall include Virginia Medicaid business only. Submission of averages for all the MCO's other non-Virginia Medicaid business is not permissible.

5.31.12 Provider advisory committee

NCQA requires the MCOs to establish and maintain a provider advisory committee. The MCO shall add to its current provider advisory committee at least two providers who have experience and expertise in serving enrollees with special needs or long-term care needs. The committee shall meet at least quarterly and its input and recommendations shall be employed to inform and direct MCO quality management and activities and policy and operations changes. The Department may conduct on-site reviews of the membership of this committee, as well as the committee's activities throughout the year.

5.31.13 Provider satisfaction survey

The MCO shall conduct a provider satisfaction survey every other year that is specific to Medicaid. The survey shall include a statistically valid sample of its participating Medicaid providers utilizing the latest version of the CAHPS survey available at the time the survey is conducted. The MCO shall submit a copy of the survey instrument and methodology to the Department. The MCO shall communicate the findings of the survey to the Department in writing within one hundred twenty (120) days after conducting the survey. The written report shall also include identification of any corrective measures that need to be taken by the MCO as a result of the findings, a time frame in which such corrective action will be taken by the MCO and recommended changes as needed for subsequent use. The first survey shall be completed during the 2009-2010 contract year. Results of the first survey shall be submitted no later than October 1, 2010, and bi-annually thereafter.

5.32 On-Line Provider Website

The MCO shall have a secure internet-based website for providers where they will be able to confirm a consumer's MCO enrollment and through this website (or through an e-mail process) allow providers to electronically submit and receive responses to prior authorization requests. This website must also include the MCO's provider manual, MCO contact information and a link to the MCO's on-line provider directory.

5.32.1 On-line provider directory

The MCO shall have an internet-based provider directory available in the same format as their DMAS-approved provider directory, and which also allows members to electronically search for MCO panel providers based on name, provider type, and geographic proximity.

5.33 Medical Records

The MCO shall have a requirement of all network providers that medical records will be maintained in paper or electronic form for all enrolled enrollees. The MCO shall require compliance of all providers and

subcontractors with HIPAA security and confidentiality of records standards. Additionally, the MCO shall maintain standards for medical records that are congruent with current NCQA guidelines. The requirements shall:

a. Include written policies to ensure that medical records are safeguarded against loss, destruction, or unauthorized use. The MCO shall have written procedures for release of information and obtaining consent for treatment.

b. Include procedures maintained by the MCO or maintained by network provider(s) so that individual medical records for each enrollee are made readily available to the Department, the contracted External Quality Review Organization (EQRO), and to appropriate health professionals. Procedures shall also exist to provide for prompt transfer of records to other in- or out-of-network providers for the medical management of the enrollee. The MCO shall use its best efforts to assist enrollees and their authorized representatives in obtaining records within ten (10) business days of the record request. The MCO will identify an individual who can assist enrollees and their authorized representatives in obtaining records. The MCO shall use its best efforts, when an enrollee changes PCPs, to assure that his or her medical records or copies of medical records are made available to the new PCP within ten (10) business days from receipt of request from the enrollee.

c. Include procedures to assure that medical records are readily available for the Department, its contracted quality assurance oversight provider, MCO-wide quality assurance and utilization review activities and provide adequate medical and other clinical data required for quality improvement, utilization management, encounter data validation, and payment activities. Specifically, the MCO shall use its best efforts to ensure that all medical records are provided within the greater of the amount of time, if specified in the request or twenty (20) business days. The Department shall be afforded access within twenty (20) calendar days to all enrollees' medical records, whether electronic or paper. Access shall be afforded within ten (10) calendar days upon request for a single record or a small volume of records. The MCO may be given only a partial list of records required for on-site audits with no advance list of records to be reviewed or one (1) week's notice, with the remaining list of records presented at the time of audit.

d. Provide for adequate information and record transfer procedures to provide continuity of care when enrollees are treated by more than one provider.

5.34 Quality Improvement (QI)

The MCO shall comply with 42 C.F.R. § 434.34, as amended, which requires each managed care organization which contracts with State Medicaid agencies to have an internal quality improvement program (QIP). Such QIP shall meet the accreditation standards of NCQA.

In addition, the MCO shall, at a minimum, as part of its established QIP, complete the following HEDIS performance studies/measures. The MCO shall assure annual improvement in its HEDIS scores until such time that the MCO is performing at least the national average HEDIS benchmark. Thereafter, the MCO is to sustain at the national average or increase its performance.

i. Prenatal and Postpartum Care
ii. CAHPS Adult Survey
iii. Comprehensive Diabetes Care
iv. Asthma – Appropriate Use of Medication
v. Cholesterol Management for Patients with Cardiovascular Conditions
vi. Pharmacotherapy of COPD Exacerbation
vii. Controlling High Blood Pressure

viii. Antidepressant Medication Management
ix. Followup After Hospitalization for Mental Illness
x. Ambulatory Care

If MCO holds more than one contract with DMAS, QI submission can be combined.

The MCO is required to follow the most current version of HEDIS and discontinue measures when retired. However, results for measures which are in effect on January 1 of the applicable contract year, must be reported to the Department by July 31 of the same year. (For example, required HEDIS in effect on January 1, 2009 must be reported by July 31, 2009.)

In conducting HEDIS measures, the MCO shall use the hybrid methodology unless otherwise stated in HEDIS technical specification guidelines. With respect to HEDIS measures, areas in which the MCO's performance rates are below national Medicaid benchmarks or have decreased by more that five (5) percentage points, a detailed, written corrective action plan must be submitted within 30 days following the release of NCQA's annual release of its Quality Compass.

The MCO shall send to the Department (annually) a copy of its quality improvement program and prior year's outcomes, including results of HEDIS, and other performance measures, quality studies, and other activities as documented in the QIP. The MCO shall take part in providing data to confirm compliance with 1915(c) waiver assurances and with the Quality Management Strategy.

The MCO's QIP shall consist of systematic activities to monitor and evaluate the care delivered to enrollees according to predetermined, objective standards and to make improvements as needed. The MCO shall correct significant systemic problems that come to its attention through internal surveillance, complaints, or other mechanisms. The CAHPS Adult Survey report shall include detailed results for all survey items. Composite scores shall be reported using both percentages and scores based upon a three-point scale. Results of survey items asking for the number of days between the recipient's request for appointments and the recipient's actual appointment date shall be reported in the average number of days. Items that ask for ratings on an eleven-point scale (i.e., "rate your doctor on a scale of 0 to 10, with 10 being best") shall report results in the following manner: Percent scored 8 to 10; 3 to 7; and 0-2).

The QIP shall illustrate a comprehensive, integrated approach that encompasses all aspects of the health care delivery system for Medicaid. The MCO shall ensure that their grievance system is tied to their quality improvement program.

The MCO shall cooperate with the Department's QIP to the extent described herein and shall, upon request, demonstrate to the Department its degree of compliance with the Department's quality standards set forth below. Additionally, the MCO shall cooperate with the Department or its designated agent with the quality review process, including data collection and data reporting on an annual basis.

5.34.1 Quality studies

The MCO shall cooperate with and ensure the cooperation of network providers and subcontractors with the external review organization contracted by the Department to perform quality studies including providing timely access to recipients' medical records in the Department's requested format. The MCO shall submit annually and upon request to the Department results of their internal quality studies. The MCO shall submit requested information by the due date provided by the EQRO or as communicated by the Department. If an extension is required, the request must be made by the MCO to the Department at least one week prior to the requested due date.

5.34.2 Performance improvement projects

The MCO shall be required to conduct one PIP annually. Each MCO selects its own project areas, with input from the Department on topic selections that are anticipated to have a beneficial effect on health outcomes and enrollee satisfaction.

For the VALTC population, it is anticipated that the PIP chosen will relate to long-term care services, health and safety aspects and special needs of this specific population. Although these projects are usually clinical in nature, given this new population there may be a PIP related to non-clinical issues (for example, related to care coordination).

It is anticipated that the focus studies that have been selected will establish a baseline for the PIPs to follow, both in the second year of the waiver and for future studies. Selection of PIPs will also take into account Medicare enrollees and requirements for Medicare Advantage and/or SNP participation.

Validation of performance improvement projects (PIPs) is conducted annually by the EQRO.

5.34.3. Coordination of QI activity with other management activity

The MCO's QI findings, conclusions, recommendations, actions taken, and results of the actions taken shall be documented and reported to appropriate individuals within the MCO's management organization and through the established QI communication channels.

QI activities shall be coordinated with other performance monitoring activities, including the monitoring of enrollees' grievances and appeals and shall reflect the most current requirements of NCQA.

5.34.4 Utilization management/authorization program description

The MCO must have a written utilization management (UM) program description which includes procedures to evaluate medical necessity, criteria used, information source, and the process used to review and approve or deny the provision of medical and long-term care services. In accordance with 42 CFR §438.210, the MCO's UM program must ensure consistent application of review criteria for authorization decisions; and must consult with the requesting provider when appropriate. The program shall demonstrate that enrollees have equitable access to care across the network and that UM decisions are made in a fair, impartial, and consistent manner that serves the best interests of the enrollees. The program shall reflect the standards for utilization management from the most current NCQA Standards. The program must have mechanisms to detect under-utilization and/or over-utilization of care including, but not limited to, provider profiles.

The MCO shall use the Department's prior authorization criteria or other medically-sound, scientifically based criteria in accordance with national standards in making medical necessity determinations. MCO criteria shall be treated by the Department as proprietary information of the MCO and shall not be subject to disclosure by the Department.

In accordance with 42 CFR §438.210, any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, must be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease. Additionally the MCO and its subcontractors are prohibited from providing compensation to UM staff in a manner so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee. In accordance with 42 CFR 438.210I, the MCO shall notify the requesting provider, and give the enrollee written notice of any decision to deny a service authorization

request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice must meet the requirements outlined in Section 5.35.5 of this contract.

The following timeframe for decision requirements apply to service authorization requests, per 42 CFR §438.210:

a. Standard Authorization Decisions

For standard authorization decisions, the contractor shall provide the decision notice as expeditiously as the enrollee's health condition requires, not to exceed fourteen (14) calendar days following receipt of the request for service, with a possible extension of up to fourteen (14) additional calendar days if:

i. the enrollee or the provider requests extension; or
ii. the MCO justifies to the Department a need for additional information and how the extension is in the enrollee's interest.

b. Expedited Authorization Decisions

For cases in which a provider indicates, or the MCO determines, that following the standard timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, the MCO must make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than three (3) working days after receipt of the request for service.

The MCO may extend the three (3) working days turnaround time frame by up to fourteen (14) calendar days if the enrollee requests an extension or the MCO justifies to the Department a need for additional information and how the extension is in the enrollee's interest.

If the MCO delegates (subcontracts) responsibilities for UM with a subcontractor, the contract must have a mechanism in place to ensure that these standards are met by the subcontractor. The UM plan shall be submitted annually to DMAS and upon revision.

The MCO must ensure that the preauthorization requirements do not apply to emergency care, family planning services, preventive services, and basic prenatal care.

The MCO (the enrollee's current MCO) shall assume responsibility for all managed care covered services authorized by either the Department or a previous MCO, which are rendered after the enrollment effective date.

5.34.5 Credentialing/recredentialing policies and procedures

The MCO's QIP shall contain the proper provisions to determine whether physicians and other health and long-term care professionals who are licensed by the Commonwealth and who are under contract with the MCO or its subcontractor(s) are qualified to perform their medical, clinical or long-term care services. The MCO shall have written policies and procedures for the credentialing process that matches the credentialing and recredentialing standards of the most recent guidelines from NCQA and in accordance with 12VAC5-408-170 of the Virginia Administrative Code. The MCO's recredentialing process shall include the consideration of performance indicators obtained through the QIP, utilization management program, grievance and appeals system, and enrollee satisfaction surveys. The MCO shall perform an annual review on all subcontractors to assure that the health care professionals under contract with the subcontractor are qualified to perform the services covered under this contract. The MCO must have in place a mechanism for reporting to the appropriate authorities any actions that seriously impact quality of

care and which may result in suspension or termination of a practitioner's license. The MCO shall report quarterly those providers who have failed to meet accreditation/credentialing standards.

5.34.6 Practice guidelines

The MCO shall establish practice guidelines as described in this section, and that are congruent with current NCQA Standards.

a. Adoption of Practice Guidelines

In accordance with 42 CFR 438.236, the MCO shall adopt practice guidelines that meet the following requirements:

i. Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field;
ii. Consider the needs of the enrollees;
iii. Are adopted in consultation with contracting health care professionals; and
iv. Are reviewed and updated periodically, as appropriate.

b. Dissemination of Guidelines

The MCO shall disseminate the guidelines to all affected providers and, upon request, to enrollees and potential enrollees. Additionally, the MCO shall provide a copy of its practice guidelines prior to signing the initial contract, upon revision or on request to the Department.

c. Application of Guidelines

MCO decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply are consistent with the established guidelines.

5.34.7 Monitoring and evaluation of enrollee grievances and appeals

The MCO shall have in place a mechanism to link its enrollee grievances and appeals system, as set forth in Section 5.35, to the QIP and credentialing process.

The MCO shall, at a minimum, track trends in grievances and appeals and incorporate this information into the QI process. The MCO's appeals and grievances system shall be consistent with Federal and State regulations and the most current NCQA standards.

5.34.8 Department oversight

The Department reserves the right to review the MCO's policies and procedures and determine conditions for formal notification to the Department of situations involving quality of care.

5.34.9 Notification to the Department of sentinel events

The MCO shall maintain a system for identifying and recording the sentinel event of a recipient's death. At a minimum, the following information must be documented on each sentinel event:

i. Recipient full name;
ii. Recipient Medicaid ID Number;
iii. Recipient's PCP's name;
iv. Recipient's cause of death and the providers involved;

v. Date of occurrence; and
vi. Source of sentinel event data.

The MCO shall provide the Department or its Agent with reports of sentinel events monthly via the Sentinel Event Reporting Form.

5.34.10 Disease management programs

The MCO must have, at a minimum, disease management programs that focus on improving the health status of enrollees diagnosed with asthma, coronary artery disease (CAD), congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD) and diabetes. The MCO must have a process in place to refer enrollees with kidney disease to the National Kidney Foundation. Nothing in this section shall limit the MCO from implementing additional disease management programs.

The MCO must supply to DMAS prior to implementation a description of each disease management program, which outlines specific goals and benchmarks, and samples of materials to be sent to enrollees.

5.34.11 Waiver specific performance activities

DMAS will conduct a quarterly monitoring review of level of care determinations made by the MCO based on a statistically valid sample. Identification of inaccurate or inappropriate determinations by the MCO will result in a corrective action plan established by the MCO and approved by DMAS.

The EQRO shall conduct an annual onsite review of the MCO's processes to ensure that level of care policies and procedures are appropriate, in compliance with requirements, and adhered to. DMAS will monitor the method of sampling and provide CMS with a copy of the abstraction tool used by the EQRO for the purposes of validation.

DMAS will conduct a quarterly monitoring review of service plans developed by the MCO based on a statistically valid sample (in accordance with pre-existing QMR standards). Identification of inadequate service plans developed by the MCO shall result in a corrective action plan established by the MCO and approved by DMAS. DMAS will include analysis of data collected from the MCO in its quarterly quality reviews.

The MCO shall be responsible for verifying qualified waiver providers through its credentialing/re-credentialing process. This is in accordance with NCQA or URAC credentialing requirements. The MCO shall verify monthly through a provider report that initial and existing licensed/certified or non-licensed/non certified providers meet credentialing standards.

The MCO shall be responsible for conducting remediation of providers not meeting qualifications. The MCO shall report quarterly on the number of waiver service providers not meeting qualifications, the reason why they did not meet qualifications, and the action taken by the MCO to remediate the issue.

The MCO shall be responsible for providing provider training with technical assistance as needed. The MCO shall report quarterly the waiver service providers' staff receiving training and the topic of the training. The MCO also shall report on what trainings are needed and when they will complete them. Data will also be collected on the remediation steps taken to address the lack of training, if appropriate.

The MCO shall be responsible for ensuring the health and welfare of its EDCD Waiver participants. Consideration for health and welfare must be made during service plan development and review. The MCO shall report quarterly on the number of plans monitored for participant health and welfare. DMAS

will also conduct a quarterly review of participant records based on a statistically valid sample (in accordance with pre-existing QMR standards). DMAS will report on the number of records reviewed, the number the appropriately addressed health and welfare, and the number that did not.

Even though the MCO shall have administrative authority over how it operates the VALTC Program, DMAS will continue to serve as the single state agency and will provide oversight of the VALTC Program and the Contractors that administer it. Contractors shall be required to follow the quality assurance standards set for the EDCD Waiver fee-for-service program. DMAS will also have specific staff for VALTC Program participants and will provide contract monitoring.

Contractors shall provide a quarterly improper payment report to DMAS. This report will describe billing abuse, corrective action plans, and an overpayment/recovery report.

The Contractors shall maintain responsibility for the implementation and the monitoring of the Quality Management Strategy for EDCD Waiver participants in the VALTC Program. Data collection will be primarily done through the Contractors, and this data will be reported to DMAS on a periodic basis. DMAS will rely on data collection by the Departments of Social Services and Health related to PAS Team activities for initial level of care and plan of care development and investigations of abuse, neglect, and exploitation.

Analysis of all data collection related to the eighteen QMR assurances (Appendix I) shall be the responsibility of the MCO and the DMAS Quality Review Team, which will make recommendations regarding the State meeting requirements and assurances, as well as plans for remediation and improvement initiatives. The DMAS Quality Review Team will use existing QMR process and protocols to sample and evaluate the Contractors' adherence to the Quality Assurances. The DMAS Quality Review Team is comprised of operational and policy staff and is charged with reviewing QMS findings on a quarterly basis, establishing benchmarks and priorities, and developing strategies for remediation and improvement. The MCO, EQRO and QR Team shall also annually evaluate the effectiveness of the QMS and recommend strategies for updates and improvements to the process. The EQRO will annually publish a QMS report that outlines the quality initiatives, findings, and recommendations. The report will be posted to the DMAS website. Due to the small projected number of VALTC EDCD participants, only the VALTC data that does not compromise confidentiality will be included in the report.

5.35 Enrollee Inquiries, Grievances, and Appeals

5.35.1 Intake of inquires, grievances and appeals

The MCO shall have a system in place to refer VALTC enrollees, including dual eligibles, who submit inquiries, grievances and appeals to the most appropriate entity, and therefore, the appropriate appeals process. For inquiries, grievances and appeals filed with the MCO or with DMAS the provisions set forth herein shall apply.

The MCO must maintain a record keeping and tracking system for inquires, grievances, and appeals that includes a copy of the grievance or appeal and the entity to which the MCO referred the enrollee. This system shall distinguish Virginia Acute and Long-Term Care (VALTC) enrollees from commercial enrollees and Medallion II enrollees, if the MCO does not have a separate system for VALTC enrollees.

The MCO shall advise the enrollee of available grievance and appeal options in writing and through oral interpretive services. The written description must be available in prevalent non-English languages, at no more than a 6th grade reading level. The MCO shall include a written description of their duty to assist with the appeals process in the enrollee's Member Handbook. The handbook shall include language that

encourages enrollees to contact the MCO if the enrollee has any questions or concerns regarding appeal rights. The MCO shall maintain and publish in the Member Handbook at least one local and one toll free telephone number with TTY/TDD and interpreter capabilities for requesting assistance with an appeal.

The MCO shall have written policies and procedures that describe the grievance and appeals processes and how they operate; and the process shall be in compliance with 12VAC30-121-90, as amended. These written directives shall describe how the MCO intends to receive, track, review, and report all enrollee inquiries, grievances and appeals. The MCO shall make any changes to its enrollee grievance and appeal procedures that are required by the Department. The procedures and any changes to the procedures shall be submitted to the Department annually.

The MCO shall provide grievance and appeal forms and/or written procedures to enrollees who wish to register written grievances or appeals. Additionally, the MCO shall provide reasonable assistance in completing forms and taking other procedural steps including, but not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability. The procedures shall provide for prompt resolution of the issue and involve the participation of individuals with the authority to require corrective action. Specific requirements regarding enrollee notices, grievances, and appeals are contained herein.

The grievance and appeals processes shall be integrated with the MCO's QIP. The grievance and appeals process shall include the following:

a. Procedures for registering and responding to grievances and appeals in a timely fashion.

b. Documentation of the substance of the grievance or appeal and the actions taken.

c. Procedures to ensure the resolution of the grievance or appeal in accordance with the requirements contained herein; and

d. Aggregation and analysis of these data and use of the data for quality improvement.

5.35.2 Responses to enrollee inquiries, grievances, and appeals

The MCO shall ensure that enrollees are sent written notice of any adverse action, as defined herein, and said written notice shall inform enrollees of their right to appeal adverse decisions through the MCO as well as their right to access the Department's State fair hearing system directly. The MCO shall provide to all network providers and subcontractors information about the grievance and appeals systems to the specifications described in 42 CFR 438.10(g)(1) at the initiation of all contracts.

The MCO shall notify the provider and shall provide written notice to the enrollee whenever rendering an adverse decision. Any notice must be in accordance with the definitions, content of notice, and required timeframes listed below.

5.35.3 Inquiries made by enrollees

The MCO shall provide a timely response to all inquiries received from enrollees or on behalf of enrollees while ensuring HIPAA compliance.

5.35.4 Grievance procedures for enrollees

The MCO's grievance process shall allow the enrollee, or the enrollee's authorized representative (provider, family member, etc.) acting on behalf of the enrollee, to file a grievance either orally or in writing. The MCO shall acknowledge receipt of each grievance. Grievances received orally can be acknowledged orally. Grievances that are received telephonically may be responded to in-kind, and need not be followed-up with a written response, unless one is requested by the enrollee or the enrollee's authorized representative.

The MCO shall ensure that the individuals who make decisions on grievances were not involved in any previous level of review or decision making. In any case where the reason for the grievance involves clinical issues or relates to denial of expedited resolution of an appeal, the MCO shall ensure that the decision-makers are health care professionals with the appropriate clinical expertise in treating the enrollee's condition or disease. [42 CFR § 438.406]

The MCO shall respond to all grievances as expeditiously as the enrollee's health condition requires, not to exceed 30 (thirty) days from the date of initial receipt of the grievance. Grievances that are received telephonically may be responded to in-kind, and need not be followed-up with a written response, unless one is requested by the enrollee or the enrollee's authorized representative.

The grievance response shall include, but not be limited to, the decision reached by the MCO; the reason(s) for the decision; the policies or procedures which provide the basis for the decision; and a clear explanation of any further rights available to the enrollee under the MCO's grievance process.

5.35.5 Appeals of adverse actions by enrollee

a. Notice of Adverse Action /Content of Notice

The MCO's notice of adverse action shall be in writing and must meet the language and format requirements described in 42 CFR § 438.10. The notice shall explain the following:

i. The action taken and the reasons for the action;
ii. The enrollee's right to file an appeal with the applicable entity or entities;
iii. The enrollee's right to request a State fair hearing in accordance with 12 VAC 30-110-10 through 12 VAC 30-110-380 and as described in this section,
iv. The procedures for exercising appeal rights with the MCO and directly to DMAS,
v. The circumstances under which expedited resolution is available and how to request an expedited resolution, and
vi. The circumstances under which the enrollee has the right to request that benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the enrollee may be required to pay the costs of these services.

b. Notice of Adverse Action / Timing of Notice

The MCO shall mail the notice of adverse action within the following timeframes:

i. For termination, suspension, or reduction of previously authorized services, the notice must be issued at least ten (10) days prior to the effective date of the intended adverse action, as required in 42 CFR § 431 Subpart E.
ii. For denials the notice must be issued at the time of the denial.

iii. For standard service authorization decisions that deny services, the notice must be issued within the timeframes specified in 438.210(d).

iv. For standard service authorization decisions that extend the review timeframe in excess of the standard fourteen (14) days, the MCO shall mail the written notice no later than the 14th day to the enrollee, describing the reason for the decision to extend the timeframe and informing the enrollee of the right to file a grievance if he or she disagrees with that decision. Additionally, the MCO shall issue and carry out the review for the final determination as expeditiously as the enrollee's health condition requires and shall not exceed the date on which the extension expires.

v. For service authorization decisions not reached within the required timeframes, in accordance with 42 CFR § 438.210(d) (which constitutes a denial and is thus an adverse action), the notice shall be issued on the date that the established timeframes for review expire.

vi. For expedited service authorization decisions, the notice shall be issued as expeditiously as the enrollee's health condition requires, not to exceed three (3) working days after receipt of the request for service.

vii. For expedited service authorization decisions where the MCO has extended the three (3) working days turnaround time frame as expeditiously as the enrollee's health condition requires, not to exceed the date on which the extension expires.

5.35.6 Enrollee appeals

Enrollees have the right to appeal most "adverse action" taken by the MCO, the MCO's subcontractors or providers. The MCO shall accept appeals submitted or postmarked within thirty (30) days from the receipt of a notice of adverse action.

a. Appeals Process

The MCO's appeals process shall include the following requirements:

i. Allow the enrollee, or enrollee's authorized representative (requires written consent from the enrollee) acting on behalf of the enrollee to file an appeal either orally or in writing and unless he or she requests an expedited resolution, must follow an oral filing with a written, signed, appeal. Per 42 CFR 438.402(b) a provider, acting on behalf of the enrollee and with the enrollee's written consent, may file an enrollee appeal with the MCO and through the State Fair Hearing Process.

ii. Acknowledge receipt of each appeal.

iii. Ensure that the individuals who make decisions on appeals were not involved in any previous level of review or decision making.

iv. Ensure that the individuals who, if deciding on any of the following, are professionals with the appropriate clinical expertise in treating the enrollee's condition or disease.
   a. An appeal of a denial that is based on lack of medical necessity or level of care.
   b. An appeal that involves clinical issues.

v. Provide that oral requests for appeals are treated as appeals (to establish the earliest possible filing date for the appeal) and must be confirmed in writing unless the enrollee or the enrollee's representative requests expedited resolution.

vi. Provide the enrollee a reasonable opportunity to present evidence and allegations of fact or law in person as well as in writing. (The MCO shall inform the enrollee of the limited time available for this, especially in the case of expedited resolution.)

vii. Provide the enrollee and his or her representative opportunity, before and during the appeals process, to examine the enrollee's case file, including any medical records and any other documents and records considered during the appeals process.

viii. Include as parties to the appeal the enrollee and his or her representative or the legal representative of a deceased enrollee's estate.

ix. Continue benefits while the MCO's appeal or the State fair hearing is pending, in accordance with 42 CFR § 438.420, when all of the following criteria are met:

a. The enrollee or the provider on behalf of the enrollee files the appeal within ten (10) days of the MCO's mail date of the notice of adverse action or prior to the effective date of the MCO's notice of adverse action; and
b. The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment; and
c. The services were ordered by an authorized provider; and
d. The original period covered by the initial authorization has not expired; and
e. The enrollee requests extension of benefits.

If the final resolution of the appeal is adverse to the enrollee, that is, the MCO's adverse action is upheld, the MCO may pursue recovery of the cost of services furnished to the enrollee while the appeal was pending, to the extent that the services were furnished solely because of the requirements listed above, and in accordance with the policy described in 42 CFR §§ 431.230(b) and 438.420.

b. Standard resolution

The MCO shall respond in writing to standard appeals as expeditiously as the enrollee's health condition requires and shall not exceed thirty (30) days from the initial date of receipt of the appeal. The MCO may extend this timeframe by up to an additional fourteen (14) calendar days if the enrollee requests the extension or if the MCO provides evidence satisfactory to the Department that a delay in rendering the decision is in the enrollee's interest. For any appeals decisions not rendered within thirty (30) days where the enrollee has not requested an extension, the MCO shall provide written notice to the enrollee of the reason for the delay.

For any appeal decision that is pending the receipt of additional information, the MCO shall issue a decision within no more than 45 days from the initial date of receipt of the appeal.

c. Expedited resolution

The MCO shall establish and maintain an expedited review process for appeals where either the MCO or the enrollee's provider determines that the time expended in a standard resolution could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function. The MCO shall ensure that punitive action is neither taken against a provider that requests an expedited resolution nor supports an enrollee's appeal. In instances where the enrollee's request for an expedited appeal is denied, the appeal must be transferred to the timeframe for standard resolution of appeals.

The MCO shall issue decisions for expedited appeals as expeditiously as the enrollee's health condition requires, not to exceed three (3) working days from the initial receipt of the appeal. The MCO may extend this timeframe by up to an additional fourteen (14) calendar days if the enrollee requests the extension or if the MCO provides evidence satisfactory to the Department that a delay in rendering the decision is in the enrollee's interest. For any extension not requested by the enrollee, the MCO shall provide written notice to the enrollee of the reason for the delay. The MCO shall make reasonable efforts to provide the enrollee with prompt verbal notice of any decisions that are not resolved wholly in favor of the enrollee and shall follow-up within two calendar days with a written

notice of action.

5.35.7 MCO appeal decisions

All decisions on appeal must be in writing and shall include, but not be limited to, the following information:

a. The decision reached by the MCO;

b. The date of decision;

c. For appeals not resolved wholly in favor of the enrollee
   i. The right to request a State fair hearing and how to do so;
   ii. The right to request to receive benefits while the hearing is pending and how to make the request, explaining that the enrollee may be held liable for the cost of those services if the hearing decision upholds the MCO.

5.35.8 State fair hearing process − enrollee appeals

The MCO shall educate its enrollees of their right to appeal directly to the Department. The enrollee has the right to appeal to the Department at the same time that the enrollee appeals to the MCO; or after exhausting appeal rights with the MCO; or instead of appealing to the MCO.

Most adverse actions or appeals that are not resolved wholly in favor of the enrollee by the MCO may be appealed by the enrollee or the enrollee's authorized representative to the Department for a fair hearing conducted in accordance with 42 CFR § 431 Subpart E and the Department's Client Appeals regulations at 12 VAC 30-110-10, et. seq. Adverse actions include reductions in service, suspensions, terminations, and denials. Furthermore, the MCO's failure to act on a request for services within required timeframes may also be appealed. Appeals must be requested in writing by the enrollee or the enrollee's representative and submitted or postmarked within 30 days of the enrollee's receipt of a notice of adverse action, unless an acceptable reason for delay exists.

An acceptable reason shall include, but not be limited to, situations or events where:

a. Appellant was seriously ill and was prevented from contacting the MCO.

b. Appellant did not receive notice of the MCO's decision.

c. Appellant sent the request for appeal to another government agency in good faith within the time limit; or

d. Unusual or unavoidable circumstances prevented a timely filing.

Additionally, if the MCO's notice is "defective," i.e., does not contain the required elements, an acceptable reason for delay may exist.

For enrollee appeals through the Department's Appeals Division, the MCO is responsible for providing to the Department and to the enrollee an appeal summary describing the basis for the denial in accordance with 12 VAC 30-110-70. For standard appeals, the appeal summary must be submitted to the Department and the enrollee at least ten (10) days prior to the date of the hearing. For expedited appeals, (that meet the criteria set forth in 42 CFR § 438.410) the appeal summary must be faxed to the Department and

faxed or overnight mailed to the enrollee, as expeditiously as the enrollee's health condition requires, but no later than 4 business hours after the Department informs the MCO of the expedited appeal. The Department may require that the MCO's qualified representative(s) and expert(s) attend the hearing. The MCO is responsible for absorbing any telephone/travel expenses incurred.

The MCO shall comply with the Department's hearing process, no more or less and in the same manner as is required for all other Medicaid evidentiary hearings. The MCO shall attend and defend the MCO's decisions at all appeal hearings or conferences, in person or by telephone, or as determined by the DMAS Appeals Division. MCO travel or telephone expenses in relation to appeal activities shall be borne by the MCO. Failure to attend or defend the MCO's decisions at all appeal hearings or conferences shall result in the MCO being liable for any costs that DMAS incurs as a result of the MCO's non-compliance. The MCO shall supply the necessary expertise, including medical expertise where DMAS deems necessary in the presentation of the case, to defend its actions and shall assist the formal appeals representative in the preparation of post-hearing matters leading to the Final Agency Decision. The MCO shall comply with the Department's fair hearing decision. The Department's decision in these matters shall be final and shall not be subject to appeal by the MCO.

5.35.9 Reversed appeal resolutions

In accordance with 42 CFR §438.424, if the MCO's or the State fair hearing decision reverses a decision to deny, limit, or delay services, where such services were not furnished while the appeal was pending, the MCO shall authorize the disputed services promptly and as expeditiously as the enrollee's health condition requires. Additionally, in the event that services were continued while the appeal was pending, the MCO shall provide reimbursement for those services in accordance with the terms of the final decision rendered by the Department's Appeals Division and with the terms of this contract and applicable regulations.

5.35.10 MCO grievance and appeal reporting

The MCO shall submit to the Department by the fifteenth (15th) day of the month after the end of each month, a mutually agreed upon summary report of all provider and enrollee inquires, grievances and appeals.

The MCO shall also submit to the Department by the fifteenth (15) day of the month after the end of each month a detailed log of all enrollee grievances and appeals and all provider grievances and appeals made on behalf of an enrollee.

a. Grievance and appeal categories identified shall be organized or grouped by the following general guidelines:
    i. access to health services.
    ii. access to long term care services
    iii. utilization: medical management decisions
    iv. utilization: health services decisions
    v. utilization: long term care decisions
    vi. provider care and treatment issues
    vii. payment and reimbursement issues
    viii. administrative issues

b. The log shall contain the following information for each grievance or appeal:
    i. the date of the communication;
    ii. the enrollee's Medicaid identification number;

iii. whether the grievance or appeal was written or oral;
iv. indication of whether the dissatisfaction was a grievance or an appeal;
v. the category, specified in subsection a, of each inquiry;
vi. a description of subcategories and specific reason codes for each grievance and appeal;
vii. the resolution; and
viii. the resolution date.

The MCO may use reports from its existing Member Services system if the system meets the above-stated Department criteria as it relates to the functions outlined in this contract.

5.36 Staffing Plan

5.36.1 Changes in key staff positions

To promote continual effective communications, the MCO must notify the Department in writing of changes in key staff positions, particularly the Contract Administrator, Chief Financial Officer, Medical Director, Care Management Manager, Member Services/Operations Manager, and Information Technology staff within fifteen (15) calendar days of any change. These changes are to be reported when individuals either leave or are added to these key positions. The Department reserves the right to approve or reject rehires to project management level positions.

5.36.2 Medical management

The MCO shall provide local medical management through licensed registered nurses (RNs) or individuals with appropriate professional clinical expertise to perform care management activities for the MCO's enrollees. The MCO shall have a full-time, Virginia-based medical director who is a Virginia-licensed medical physician. Medical management staffing shall be at a level that is sufficient to perform all necessary medical assessments and to meet all enrollees' care management needs at all times.

5.36.3 Virginia base of operations

The MCO shall have a dedicated Virginia Medicaid project manager located in an operations/business office within the Commonwealth of Virginia. The Virginia project manager shall be authorized and empowered to make operational and financial decisions including rate negotiations for Virginia business, claim payment, and provider relations/contracting. The project manager shall be able to make decisions about program expansions and shall represent the MCO at the Department's meetings. The Virginia-based location must include a designee who can respond to issues involving systems and reporting, appeals, quality assessment, member services, pharmacy management, medical management, and care management. The Virginia office shall include a Virginia licensed and Virginia based medical director and dedicated staff able to perform member advocacy and provider network development. Provider relations staff shall be located within the geographic region where the MCO operates. Member Advocates must assist enrollees in writing complaints and are responsible for monitoring the complaint through the MCO's complaint process. The Department does not require claims, medical management, customer service, pharmacy management, IT, accounting or member services to be physically located in Virginia.

Prior to diverting any of the specified key personnel for any reason, the MCO shall notify the Department within two (2) business days of the decision and shall submit justification (including proposed substitutions) in sufficient detail to permit evaluation of the impact on the delivery of covered services.

5.36.4 Responsiveness to the Department

The MCO shall acknowledge receipt of the Department's written, electronic, or telephonic requests for assistance, including care management evaluation requests and requests to change MCO (good cause), involving enrollees or providers as expeditiously as the enrollee's health condition requires or no later than two business (2) days of receipt of the request from the Department. The MCO's acknowledgement must include a planned date of resolution. A detailed resolution summary advising the Department of the MCO's action and resolution shall be rendered to the Department in the format requested. The Department's requests for care management services and/or requests for the MCO to contact the enrollee/provider must occur within the time frame set forth by the Department.

The Department's urgent requests for assistance such as issues involving legislators, other governmental bodies, or as determined by the Department, must be given priority by the MCO and completed in accordance with the request of and instructions from the Department. The Department shall provide guidance with respect to any necessary deadlines or other requirements. A resolution summary, as described by the Department shall be submitted to the Department.

5.37 Subcontractor Management and Monitoring

The MCO shall be responsible for the administration and management of all aspects of this contract. The MCO may enter into subcontracts for the provision or administration of any or all covered services or enhanced services. Subcontracting does not relieve the MCO of its responsibilities to the Department or enrollees under this contract. The Department shall hold the MCO accountable for all actions of the subcontractor and its providers. Additionally, for the purposes of this Contract, the subcontractor's providers shall also be considered providers of the MCO.

If the MCO elects to utilize a subcontractor, the MCO shall ensure that the subcontractor shall not enter into any subsequent contract or subcontracts for any of the work contemplated under the subcontract for purposes of this contract, without prior approval of the MCO. No subcontract or other delegation of responsibility shall terminate or reduce the legal responsibility of the MCO to the Department to ensure that all activities under this contract are carried out.

The MCO must ensure that subcontractors and providers in their networks are licensed by the State and have received proper certification or training to perform the specific services for which they are contracted. The MCO shall neither participate with nor enter into any provider contract with any individual or entity that has been excluded from participation in federal health care programs.

5.37.1 Delegation and monitoring requirements

In accordance with 42 CFR §438.230, all subcontracts entered into pursuant to this contract shall meet the following delegation and monitoring requirements.

a. Delegation Requirements
    i. All subcontracts shall be in writing;
    ii. Subcontracts shall fulfill the requirements of this contract and applicable Federal and State laws and regulations;
    iii. Subcontracts shall specify the activities and reporting responsibilities delegated to the subcontractor; and,
    iv. Subcontracts shall provide provisions for revoking delegation or imposing sanctions in the event that the subcontractor's performance is inadequate.

b. Monitoring Requirements
    i. The MCO shall perform on-going monitoring of all subcontractors.
    ii. The MCO shall perform a formal review of all subcontractors at least annually.
    iii. The MCO shall monitor encounter data of its subcontractor before the data is submitted to the Department. The MCO shall apply certain key edits to the data to ensure accuracy and completeness. These edits shall include, but not be limited to, recipient and provider identification numbers, dates of service, diagnosis and procedure codes, etc.
    iv. As a result of monitoring activities conducted by the MCO (through on-going monitoring and/or annual review), the MCO shall identify to the subcontractor deficiencies or areas for improvement, and shall require the subcontractor to take appropriate corrective action.

5.37.2 HIPAA requirements

To the extent that the MCO uses one or more subcontractors or agents to provide services under this contract, and such subcontractors or agents receive or have access to protected health information (PHI), each such subcontractor or agent shall sign a Business Associate Contract with the MCO that complies with HIPAA.

The MCO shall ensure that any agents and subcontractors to whom it provides PHI received from the Department (or created or received by the MCO on behalf of the Department) agree in writing to the same restrictions, terms, and conditions relating to PHI that apply to the MCO in this contract. The Department shall have the option to review and approve all such written contracts between the MCO and its agents and subcontractors prior to their effectiveness.

5.37.3 Department review requirements

All subcontracts must ensure the level and quality of care required under this contract. Subcontracts with the MCO for delegated administrative and medical services in the areas of planning, finance, reporting systems, administration, quality assessment, credentialing/re-credentialing, utilization management, enrollee services, claims processing, or provider services must be submitted to the Department at least thirty (30) calendar days prior to their effective date. This includes subcontracts for transportation, vision, mental health, prescription drugs, or other providers of service.

All subcontracts, amendments, and revisions thereto shall be approved in advance by the Department. All subcontracts shall be maintained in accordance with the applicable terms of this contract. Once a subcontract has been executed by all of the participating parties, a copy of the fully executed subcontract shall be sent to the Department within 30 days of execution.

All subcontracts are subject to the Department's written approval. The Department may revoke such approval if the Department determines that the subcontractors fail to meet the requirements of this contract. Subcontracts which require the subcontractor to be responsible for the provision of VALTC covered services must include the terms set forth in Appendix J, and, for the purposes of this contract, that subcontractor shall be considered both a subcontractor and network provider. Subcontracts will be considered approved if the Department has not responded within fifteen (15) calendar days of the date of Departmental receipt of the request.

The MCO shall require all subcontractors to submit to the Department, for review and approval, all mass-generated letters intended for provider and/or enrollee distribution, 30 days prior to their planned distribution. This does not include materials for wellness or business purposes but does extend to letters to generate provider enrollment or advising enrollees of enrollment/disenrollment or other Department

functions. The Department shall review and return these documents with any recommended changes within three (3) business days. (Note: this turnaround time does not apply to mailings related to pre-assignment, review of EOC booklets/handbooks, contractor marketing materials, or other mailings whose review process is identified elsewhere in this contract.)

5.37.4 Notice of subcontractor termination

When a subcontract that relates to the provision services related to this contract is being terminated between the MCO and a subcontractor, the MCO shall give at least thirty (30) days prior written notice of the termination to the Department. Such notice shall include, at a minimum, a MCO's intent to change to a new subcontractor for the provision of said services, an effective date for termination and/or change, as well as any other pertinent information that may be needed. In addition to prior written notice, the MCO shall also provide the Department with a transition plan, when requested, which shall include, at a minimum, information regarding how continuity of care will be maintained. The MCO's transition plan shall also include provisions to notify impacted or potentially impacted provider and/or participants of the change. Failure to adhere to guidelines and requirements regarding administrative responsibilities, including subcontract requirements may result in the application of liquidated damages. The Department reserves the right to require this notice requirement and procedures for other subcontracts if determined necessary upon review of the subcontract for approval.

5.38 Fraud and Abuse

The MCO shall have in place policies and procedures for ensuring protections against actual or potential fraud and abuse. The MCO shall have a comprehensive Virginia Medicaid Program Integrity Plan to detect, correct and prevent fraud, waste, and abuse. The Virginia Medicaid Program Integrity Plan shall define how the MCO will adequately identify and report suspected fraud and abuse by enrollees, by network providers, by subcontractors and by the MCO. The Virginia Medicaid Program Integrity Plan shall be submitted in response to this contract and annually thereafter. The MCO shall include a plan with set goals and objectives and describe the processes involved including data mining, software, audit findings for the Virginia Medicaid. All fraudulent activities or other program abuses shall be subject to the laws and regulations of the Commonwealth of Virginia and/or Federal laws and regulations.

The MCO shall develop a written integrity plan specific to its Virginia Medicaid program. The MCO shall have in place a process for assessment of all claims for fraudulent activity by enrollees and providers through utilization of computer software or through periodic audits of medical records.

The MCO shall submit electronically to the Department each quarter any findings of fraud and abuse. The report shall include the following:

a. Number of cases by providers and recipients investigated with resolution

b. Cases referred to the Department for action must include:
    i. provider/recipient name
    ii. date case was opened
    iii. reason(s) for initiating case
    iv. date case was cleared (if applicable)
    v. findings/corrective action taken
    vi. overpayment amount
    vii. recovery action taken/completed

c. The MCO shall provide the Department on October 1st each year an annual summary of activities and

results.

d. The Department shall share fraudulent provider activity with the MCO through an electronic database that shall be updated at least monthly.

e. The MCO shall refer recipients and providers, who have notified the MCO of suspected fraud or abuse, to the Department.

f. The MCO shall establish written policies for all employees of the MCO, any MCO or agent of the MCO, that provide detailed information about the False Claims Act established under sections 3729 through 3733 of title 31. The written policies shall include detailed provisions regarding the MCO's policies for detecting and preventing fraud, waste, and abuse. Any MCO employee handbook shall provide a specific discussion of the Virginia Fraud Against Taxpayers Act, the rights of employees to be protected as whistleblowers, and the MCO's policies and procedures for detecting and preventing fraud, waste and abuse in accordance with Virginia Fraud Against Taxpayers Act, Va. Code § 8.01-216.1 through 8.01-216.19.

In accordance with 42 CFR §438.608, the MCO's Program Integrity Plan must address the following requirements:

a. Written Policies and Procedures

The MCO shall have in place written policies, procedures, and standards of conduct that articulate the MCO's commitment to comply with all applicable Federal and State Standards for the prevention, detection and reporting of incidents of potential fraud and abuse by enrollees, by network providers, by subcontractors and by the MCO. As required in 42 CFR § 455.1, the MCO's Program Integrity Plan must include a method to verify whether services reimbursed were actually furnished to the member.

The MCO should have, at a minimum, the following policies and procedures in place:

i. A commitment to comply with applicable statutory, regulatory and contractual commitments.
ii. A process to respond to potential violations of Federal and State criminal, civil, administrative laws, rules and regulations in a timely basis (no later than 30 days after the determination that there is a potential violation of civil, criminal or administrative law may have occurred).
iii. Procedures for the identification of potential fraud, waste and abuse in a MCO's network.
iv. A process to ensure the MCO, agents and brokers are marketing in accordance with applicable federal and state laws, including state licensing laws, and CMS policy.
v. A process to identify overpayments at any level within the MCO's network and properly recover such overpayments in accordance with federal and state policy.
vi. Procedures for corrective actions designed to correct any underlying problems that result in program violations and prevent future misconduct.
vii. Procedures to retain all records documenting any and all corrective actions imposed and follow-up compliance reviews for future health oversight purposes and/or referral to law enforcement, if necessary.

b. Compliance Officer

The MCO shall designate a compliance officer and a compliance committee, accountable to senior management, to coordinate with the Department on any fraud or abuse case. The MCO may identify different contacts for enrollee fraud and abuse, network provider fraud and abuse, subcontractor fraud and abuse, and MCO fraud and abuse.

c. Training and Education

The MCO shall establish effective program integrity training and education for the Compliance Officer, all MCO staff and subcontractors.

d. Effective Lines of Communication Between MCO Staff

The MCO shall establish effective lines of communication between the compliance officer, other MCO staff, enrollees, and subcontractors. Contractors shall have a system in place to receive, record, and respond to compliance questions, or reports of potential or actual non-compliance from employees and subcontractors, while maintaining confidentiality. The MCO shall also establish effective lines of communication with its enrollees.

Contractors shall establish a process to document and track reported concerns and issues, including the status of related investigations and corrective action.

e. Enforcement of Standards through Well-Publicized Disciplinary Guidelines

The MCO shall enforce program integrity standards through well-publicized disciplinary guidelines.

f. Internal Monitoring and Audit

The MCO shall establish and implement provisions for internal monitoring and auditing.

Procedures for internal monitoring and auditing shall attest and confirm compliance with Medicaid regulations, contractual contracts, and all applicable state and federal laws, as well as internal policies and procedures to protect against potential fraud, waste or abuse.

Contractors shall have a system or plan of ongoing monitoring that is coordinated or executed by the Compliance Officer to assess performance in, at a minimum, areas identified as being at risk. The plan shall include information regarding all the components and activities needed to perform monitoring and auditing, such as Audit Schedule and Methodology, and Types of Auditing.

The plan shall include a schedule that includes a list of all the monitoring and auditing activities for the calendar year. Contractors shall consider a combination of desk and on-site audits, including unannounced internal audits or “spot checks,” when developing the schedule.

Contractors shall produce a standard audit report that includes, at a minimum:

i. Purpose
ii. Methodology
iii. Findings
iv. Recommendations

In developing the types of audits to include in the plan Contractors shall:

i. Determine which risk areas will most likely affect their organization and prioritize the monitoring and audit strategy accordingly.
ii. Utilize statistical methods in:
    1. Randomly selecting facilities, pharmacies, providers, claims, and other areas for review;
    2. Determining appropriate sample size; and
    3. Extrapolating audit findings to the full universe.
iii. Assess compliance with internal processes and procedures.
iv. Review areas previously found non-compliant to determine if the corrective actions taken have fully addressed the underlying problem.
v. Contractors shall also include in their plan a process for responding to all monitoring and audit results. Corrective action and follow-up shall be led by the Compliance Officer and include actions such as the repayment of identified overpayments and making reports.
vi. The Compliance Officer should maintain a records system to track all compliance actions taken and outcomes of any follow-up reviews to evaluate the success of implementation efforts that may be provided, if necessary, to CMS or to law enforcement, and provide updates on the monitoring and auditing results and corrective action to the Compliance Committee on at least a quarterly basis.
vii. Contractors shall develop as part of their work plan a strategy to monitor and audit subcontractors involved in the delivery of the benefits. Specific data should be analyzed from subcontractors, as applicable and appropriate, and reviewed regularly as routine reports are collected and monitored.
viii. Contractors shall include routine and random auditing as part of their contractual contract with subcontractors. Contractors shall include in their work plan the number of subcontractors that will be audited each year, how the subcontractors will be identified for auditing, and should make it a priority to conduct a certain number of on-site audits.
ix. Contractors are encouraged to invest in data analysis software applications that give them the ability to analyze large amounts of data. Data analysis should include the comparison of claim information against other data (e.g., provider, drug provided, diagnoses, or beneficiaries) to identify potential errors and/or potential fraud.

g. Process for Reporting Potential or Actual Fraud and Abuse

The MCO shall provide information and a procedure for enrollees, network providers and subcontractors to report incidents of potential or actual fraud and abuse to the MCO and to the Department.

h. Prompt Response to Reported Offenses

The MCO shall report all potential or actual fraud and abuse to the Department. The MCO shall have procedures for ensuring prompt responses to detected offenses and development of corrective action initiatives.

i. Development of Corrective Action Initiatives

The MCO's Program Integrity Plan shall include provisions for corrective action initiatives. The Contractors shall conduct appropriate corrective actions (for example, repayment of overpayments and disciplinary actions against responsible individuals) in response to potential violations. A corrective action plan should be tailored to address the particular misconduct identified. The

corrective action plan should provide structure with timeframes so as not to allow continued misconduct.

j. Time Frame for Reporting Fraud and Abuse to the Department

The MCO shall report incidents of potential or actual fraud and abuse to the Department within forty-eight (48) hours of initiation of any investigative action by the MCO or within forty-eight (48) hours of MCO notification that another entity is conducting such an investigation of the MCO, its network providers, or its enrollees.

The MCO shall report all incidents of potential or actual marketing services fraud and abuse immediately (within 48 hours of discovery of the incident). All reports shall be sent to the Department in writing and shall include a detailed account of the incident, including names, dates, places, and suspected fraudulent activities.

k. Cooperation with State and Federal Investigations

The MCO shall cooperate with all fraud and abuse investigation efforts by the Department and other State and Federal offices.

5.39 Transition Plan

The MCO shall submit in a response to this contract a transition or continuation of coverage plan that documents how it will provide service to the enrollee that is under treatment for medically necessary acute and long-term care covered services the day before the effective date of this contract. The MCO shall authorize the continuation of said covered services without any significant form of prior approval.

5.39.1 Transition management

The MCO shall coordinate with the Department's FFS program, current vendors and each of the Department's contracted Medallion II MCOs to effect a smooth transition of care. Transition management includes a process whereby inquiries received for dates of service on or after the contract implementation are redirected to the MCO.

In order to ensure uninterrupted service delivery, the MCO shall accept notifications of prior authorizations from the Department's contracted MCOs, current vendors and/or the Department for whom prior approvals were issued. To the extent that the approvals are for covered services and are within the parameters of the Department approved policies and procedures for prior approvals, the MCO shall accept and honor those prior approvals.

DMAS shall notify the MCO of enrollees who are transitioned from fee-for-service to the managed care system. It shall be the MCO's responsibility to include, as part of the response to this contract, the plans to transition enrollee's between the two systems.

5.39.2 Transition to managed care for eligible consumers

Eligible consumers receiving Medicaid services through the fee-for-service delivery system (FFS) are generally free to seek care from any provider that accepts the Medicaid card but seldom have the benefits of comprehensive care management or care coordination. Such consumers have chronic or critical conditions and are most likely to be frequent and/or high users of health care, including behavioral health services. Individuals may often have multiple co-morbidities, serious physical and cognitive limitations

and other issues such as lack of social or family support which will present unique care management challenges for the MCOs. MCOs' efforts to effectively coordinate care for the eligible VALTC population will be most critical as members transition from the fee-for-service (FFS) delivery system to the managed care program. For this reason the primary goals for the MCO's membership must be to provide the benefits of enhanced care coordination, enhanced access to preventive and specialized care, care management and expanded member services and education with minimal disruption to members' established relationships with providers and existing care treatment plans.

Contractors shall, in response to this contract, develop a transition plan that effectively addresses the unique care coordination issues for each VALTC member in the critical first three months of MCO membership.

The transition plan shall include a minimum:

a. A member profile as described below;

b. A strategy for the new member to obtain care therapies from appropriate sources for care as an MCO member; and

c. Reported scheduled health and long-term care services as described below.

Contractors shall have an effective outreach process to identify each new member's existing and or potential health care needs that result in a new member profile. This can be achieved through data-mining of fee-for-service utilization history provided by the Department, information regarding current treatments, upcoming appointments and surgeries, etc.., obtained during the enrollment process and reported to the MCOs by the Department or enrollment broker and direct member contact. A complete member profile would include but not be limited to:

a. Identification of health care needs, including those services received through state-sub-recipient agencies (e.g., the Virginia Department of Mental Health Mental Retardation and substance Abuse Services [DMHMRSAS]);

b. Existing sources of care (primary physician, specialists, case manager(s), ancillary and other and other care givers); and

c. Current care therapies for all aspects of health care services, including scheduled health care appointments, planned and/or approved surgeries (inpatient or outpatient), ancillary or medical therapies, prescribed drugs, approved home health care, scheduled lab/radiology tests, necessary/approved durable medical equipment, supplies and needed/approved transportation arrangements.

5.39.3 Transition upon termination

The MCO shall provide for continuity of services, which is vital to the Department's overall effort to provide managed care services to its Medicaid population. Continuity of service, therefore, must be maintained at a consistently high level without interruption. Upon expiration or termination of this contract, a successor (i.e., another contractor) must continue these services and may need transitional assistance, such as training, transferring records and encounter data, etc. The MCO shall, therefore, be required to prepare a transition plan to provide phase-in, phase-out services and cooperate in an effort to positively effect an orderly and efficient transition to a successor.

5.40 Virginia Medicaid Management Information Systems (VAMMIS) Interface Requirements

The MCO shall have in place management information systems capable of furnishing the Department with timely, accurate, and complete information about the VALTC program. Such information systems shall:

a. Accept and process weekly and monthly enrollment reports and reconcile them with the MCO enrollment/eligibility file;

b. Accept and process provider claims and encounter data, as set forth in this contract;

c. Track provider network composition and access, and grievances and appeals as set forth in this contract;

d. Perform quality improvement activities, as set forth in this contract;

e. Furnish the Department with timely, accurate and complete clinical and administrative information, as set forth in this contract;

f. Ensure that data received from providers is accurate, and complete by:
    i. Verifying the accuracy and timeliness of reported data;
    ii. Screening the data for completeness, logic, and consistency;
    iii. Collecting service information in standardized formats as set forth in this contract; and

g. In accordance with requirements set forth in 1932(d)(4) and 1173(b)(2) of the Social Security Act, the MCO shall assign unique identifiers to providers, including physicians, and must require that providers use these identifiers when submitting data to the MCO.

The MCO shall make available to the Department and CMS, upon request, all data collected by the MCO in relation to and in support of the program.

Any reference to "systems" in this contract shall mean the MCO's MIS unless otherwise specified. If the MCO subcontracts any MIS functions, then these requirements shall apply to the subcontractor's systems. For example, if the MCO contracts with a mental health network to provide services and pay claims/collect encounters, then these requirements shall apply to the mental health network's systems. However, if the MCO contracts with a mental health network only to provide mental health services, then these requirements shall not apply.

The MCO shall accommodate and modify future system changes/enhancements to claims processing or other, related systems as soon as possible after being notified by the State of the change or enhancement. The MCO shall advise the Department in writing of the anticipated implementation date of the system changes/enhancements. In addition, the system shall be able to accommodate all future requirements based upon Federal and State statutes, policies and regulations. Unless otherwise agreed by the State, the MCO shall be responsible for the cost of these changes.

5.41 Electronic Data Submission Including Encounter Claims

The MCO may not transmit protected health information (PHI) over the Internet or any other insecure or open communication channel unless such information is encrypted or otherwise safeguarded using procedures no less stringent that those described in 45 CFR § 142.308(d).

If the MCO stores or maintains PHI in encrypted form, the MCO shall, promptly at the Department's request, provide the Department with the software keys to unlock such information.

5.41.1 Electronic Data Interchange (EDI)

Each party will transmit documents directly or through a third party value added network. Either party may select, or modify a selection of, a Value-Added Network (VAN) with thirty (30) days written notice.

Each party will be solely responsible for the costs of any VAN with which it contracts. Each party will be liable to the other for the acts or omissions of its VAN while transmitting, receiving, storing or handling documents. Each party is solely responsible for complying with the subscription terms and conditions of the VAN he or she selects, and for any and all financial liabilities resulting from that subscription contract.

5.41.2 Test data transmission

Each party agrees to actively send and receive test data transmissions until approved. Supplier agrees to receive redundant transmission (e.g. faxed copy and electronic), if required by the Department, for up to thirty (30) days after a successful EDI link is established.

5.41.3 Garbled transmissions

If a party receives an unintelligible document, that party will promptly notify the sending party (if identifiable from the received document). If the sending party is identifiable from the document but the receiving party failed to give notice that the document is unintelligible, the records of the sending party will govern. If the sending party is not identifiable from the document, the records of the party receiving the unintelligible document will govern.

5.41.4 Certification

Any payment information from the MCO that is used for rate setting purposes (e.g. any encounter data) or any payment related data required by the state must be certified with the signature of the MCO's Chief Financial Officer, Chief Executive Officer, or a person who reports directly to and who is authorized to sign for the Chief Financial Officer or Chief Executive Officer of the MCO. The certifications shall attest that the MCO has reviewed the encounter data or other information and attests, based on best knowledge, information, and belief as of the date signed and submitted that it is accurate, complete and truthful.

The MCO must use Appendix K, Certification of Encounter Data, on a monthly basis reflecting prior submissions of encounters; and Certification of Data, for certification of non-encounter payment related data submissions within one (1) week of the date of submission.

The use of this form will ensure that the amount paid to providers by the MCO shall not be subject to Freedom of Information Act (FOIA) requests. The Department can deny FOIA requests for such protected information pursuant to § 2.2 4342 (F) of the Procurement Act.

5.41.5 Enforceability and admissibility

Any document properly transmitted pursuant to this Contract will be deemed for all purposes (1) to be a "writing" or "in writing," and (2) to constitute an "original" when printed from electronic records established and maintained in the ordinary course of business. Any document which is transmitted pursuant to the EDI terms of this Contract will be as legally sufficient as a written, signed, paper

document exchanged between the parties, notwithstanding any legal requirement that the document be in writing or signed. Documents introduced as evidence in any judicial, arbitration, mediation or administrative proceeding will be admissible to the same extent as business records maintained in written form.

5.41.6 Timeliness, accuracy, and completeness of data

The MCO must ensure that all electronic data submitted to the Department are timely, accurate and complete. At a minimum, encounter data and provider rosters will be submitted via electronic media.

In the event that electronic provider files are returned to the MCO due to errors, the MCO agrees to process incorrect data and resubmit within five (5) business days. All other electronic data returned for errors must be corrected and resubmitted within thirty (30) days. The MCO agrees to correct encounter claims where appropriate and resubmit corrected encounter claims in accordance with the specifications set forth in this subsection.

The MCO must evaluate the completeness of data from their providers on a periodic basis, in particular providers who are capitated or paid under a global fee arrangement. The MCO must report annually the plan used by the MCO, including frequency of review, to ensure encounter data completeness. Any deficiencies found through the review process must be reported to the Department within 60 calendar days. A corrective action plan to address any deficiencies found must be provided to the Department within 30 calendar days after notification of any deficiencies.

5.41.7 Encounter claims data submission

For the purposes of this contract, an encounter is any service received by the enrollee and processed by the MCO and its subcontractors. The MCO shall submit encounters/claims for all services it covers including, but not limited to, inpatient and outpatient procedures, including psychiatric procedures, EPSDT screens (for newborns 0-3 months), long-term care services, transportation, pharmacy, durable medical equipment (DME), and home health care services. Each MCO will be required to obtain and use separate service center IDs for VALTC and Medallion II, so the encounter data will need to be submitted on separate files. This allows DMAS to distinguish which encounters are being submitted for VALTC vs. those for Medallion II. The MCO is responsible for submission of data from all of its subcontractors to the State or its agent in the specified format that meets all specifications required by the Department and matches the requirements placed on the MCO by the Department for encounters. This data shall be submitted and on a timely basis.

All encounters shall be submitted using the nationally recognized formats defined below:

Hospital and Professional Claims – Submit using the American National Standards Institute (ANSI) 837, version 40.10 with addenda.

Pharmacy Claims – Submit using the National Council for Prescription Drug Programs (NCPDP) Batch Version 1.1.

All encounters must be submitted to the Virginia Medicaid Management Information System (VAMMIS) Gateway System to interface with the First Health File Transfer Protocol (FTP) Server.

Submissions must be made at least monthly and may be made more frequently with the approval of the Department. Files with HIPAA defined level 1 or level 2 errors in the ISA, GS, GE, or ISE records will be rejected and a negative 997 sent back to the submitter. The entire file must be resubmitted after the problem is fixed. Files with HIPAA defined level 1 or level 2 errors inside a ST-SE loop will have that ST-SE loop rejected and a negative 997 will be sent back to the submitter identifying the loop. Any other

ST-SE loops, which do not have level 1 or level 2 errors, will be processed. Only the rejected ST-SE loops should be resubmitted after fixing the problem. Errors on rejected files or ST-SE loops must be corrected and resubmitted within thirty (30) days of the date.

Except for encounters involving appeals, the MCO shall submit to the Department ALL electronic encounter claims within sixty (60) calendar days of receipt or within sixty (60) calendar days of inpatient discharge. Late data will be accepted, but the Department reserves the right to set and adjust timeliness standards as required in order to comply with State and Federal reporting requirements. The MCO is strongly encouraged to submit encounter data as received and discouraged from waiting the full time allotted before submitting the encounter data to the Department. The Department reserves the right to require written explanations of all appeals.

The MCO shall be required to pass a testing phase for each of the encounter claim types identified by the Department before production encounter data will be accepted. The MCO shall pass the testing phase for all encounter claim type submissions within twelve calendar weeks from the effective date of the change.

The MCO shall submit the test encounter data to the Department's fiscal agent electronically according to the specifications of the HIPAA Implementation and Companion Guidelines.

The MCO shall be responsible for passing a phased-in test process prior to submitting production encounter data. The MCO shall utilize production encounter data, systems, tables, and programs when processing encounter test files.

5.41.8 Encounter data reconciliation

The MCO shall fully cooperate with all DMAS efforts to monitor the MCO's compliance with the requirements of encounter data submission including encounter data accuracy, completeness, and timeliness of submission to the DMAS Fiscal Agent. The MCO shall comply with all requests related to encounter data monitoring efforts in a timely manner.

5.41.9 Administrative provider identification numbers

The MCO is responsible to ensure that all encounter claims are identified with an active NPI/API. Monthly, DMAS produces a provider file that includes all active and terminated Virginia Medicaid Providers. The MCO is responsible for maintaining the correct provider NPI/API for the claim and service date. The MCO will make best effort that as part of its credentialing process all providers, including ancillary providers, (i.e. vision, pharmacy, etc.), apply for enrollment in the Medicaid program. Non-medical providers will be issued an API by DMAS.

Upon receipt of the DMAS provider file, the MCO will add, update, edit, etc. the NPI/API number, by effective date, as appropriate. Monthly, or in the event that in a given month no Administrative Provider Ids are required, then as needed, the MCO will submit a file for any provider claim(s) that an active NPI/API number is not available. The file layout is defined below:

i. NPI
ii. Provider Type
iii. Last Name
iv. First Name
v. Middle Initial
vi. Suffix
vii. Title
viii. Address

ix. City
x. State
xi. Zip (5+ 4)
xii. Contact Name
xiii. Phone (including area code)
xiv. Provider Begin Date
xv. License Number
xvi. State of License
xvii. License Begin Date
xviii. License End Date
xix. Specialty
xx. Languages
xxi. Tax ID

This should be submitted monthly via e-mail, CD or diskette to the attention of the Encounter Contract Analyst. As of the effective date of mandatory compliance with the CMS NPI Rule, no encounter record will be accepted unless the provider has an active record (NPI/API) in the VA MMIS system.

5.42 Reporting

The MCO shall establish and maintain all necessary systems, policies and procedures to fulfill the reporting requirements in this contract. The encounter data aspects of these requirements shall conform to the nationally recognized standard (ANSI or NCPDP) currently in use by DMAS. The Department reserves the right to change/modify these requirements as is necessary to meet State and Federal (including HIPAA) reporting requirements.

The MCO shall comply with State and Federal (42 CFR Part 441 Subpart F as amended) reporting and compliance requirements for sterilizations and hysterectomies, reporting the policy and processes used to monitor compliance to the Department prior to signing the initial contract, upon revision or in request.

The MCO shall submit annually an updated company background history that includes any awards, major changes or sanctions imposed since the last annual report. The MCO shall also submit the same information for all of its subcontractors.

If MCO holds more than one Medicaid managed care contract with DMAS, submission can be combined, unless otherwise noted.

5.42.1 Annual reports

Requirement	**Basis**	**Dual MA or SNP Pursuant to 42CFR 422.152*(with or without EDCD)**	**Dual Not enrolled in MA or SNP (with or without EDCD)**	**Non-dual eligible EDCD**
Results of Quality Improvement Plans, Focus Studies and Performance Improvement Plans	42CFR 438.204 42CFR 438.236 42CFR 438.240 42CFR 438.242	X	As available	X
Practice Guidelines	42CFR 438.236	X	As available	X

HEDIS Measures	42CFR 438.236 42CFR 438.240 42CFR 438.242	X	As available	X
Marketing Plan	42CFR 438.104	X	X	X
Formulary and Prior Auth Requirements	42CFR 441.20 42CFR 431.51	X	X	X
NCQA or other Accreditation		X	X	X
Utilization Management Plan	42CFR 438.240	X	As available	X
Enhanced Services offered		X	As available	X
Annual audit report submitted to Bureau of Insurance (BOI)	42CFR 438.106 42CFR 438.116	X	X	X
Credentialing requirements to include waiver service providers	42CFR 438.206 42CFR 438.214 42CFR 438.230 42CFR 438.236	X	As applicable	X
Submit handbook for approval Updates to handbook, with cover letter explicitly identifying sections that have changed	DMAS	X	X	X
Enrollee Information Packet and all enrollment, disenrollments, and educational documents and materials made available to enrollees	DMAS	X	X	X
Program Integrity Plan (policies and procedures for ensuring protection against actual or potential fraud and abuse)	42CFR441.302 1915(c) waiver	X	X	X
Written policies and procedures for the prevention, detection, and reporting of incidents of potential fraud and abuse by enrollees, by network providers, by subcontractors, and by the MCO	42CFR441.302 1915(c) waiver	X	X	X
Audit by Independent Auditor	DMAS	X	X	X
Insurance Coverage Verification to include Professional Liability Insurance for MCO's Medical Director, Worker's Compensation, Employer's Liability, Commercial General Liability, and Automobile Liability	DMAS	X	X	X

*MCOs will submit a copy of their required MA/SNP quality reports to DMAS for the dually eligible population.

Additional Requirements for 1915(c) Waiver Compliance (EDCD participants only):

i. Summary of level of care (LOC) reviews completed

ii. Review of Service Facilitation services and attendant requirements by MCO Care Coordinator

5.42.2 Quarterly reports

Requirement	Basis	Dual MA or SNP Pursuant to 42CFR 422.152 (with or without EDCD)	Dual Not enrolled in MA or SNP (with or without EDCD)	Non-dual eligible EDCD
Provider Network Files (to include LTC providers)	42CFR 438.206 42CFR 438.207	X	As available	X
Abuse, Corrective Action, Overpayment/Recovery Report	1915(c) waiver	As available	As available	X
Report on sentinel events	1915(c) waiver	X	X	X
Live Birth Outcomes Report	DMAS	X	X	X
Listing of Excluded Providers	42CFR441.302 1915(c) waiver	As available	As available	X
Listing of Providers who Have Failed Accreditation/Credentialing	42CFR441.302 1915(c) waiver	As available	As available	X

Additional Requirements for 1915(c) Waiver Compliance (EDCD participants only):

a. LOC Re-evaluations:
   i. Quarterly report on the number of LOC re-evaluations due during indicated quarter, number of reviews completed, number of participants who met EDCD criteria, number who did not meet criteria.
   ii. DMAS will select from the MCOs a statistically significant sample to evaluate appropriateness of LOC determinations. Any participants identified as no longer meeting LOC will be reassessed by DMAS Long-Term Care staff. If it is verified LOC is not met, DMAS LTC staff will process termination from VALTC and afford appeal rights.

b. Service Plans:
   i. Quarterly report on the number of service plan updates due during indicated quarter and number of reviews completed.
   ii. DMAS provides to each MCO a random sample for which the MCO must provide participants' service plans. MCO submits information to DMAS. DMAS LTC staff will review for required items to include timely service plan revisions, service plan adequacy, participant choice, and participant health, safety, and welfare assurances.

c. Providers Qualifications:
   i. Quarterly report on provider qualifications containing the following;
      1. Number of enrolled waiver (agency) providers under contract for quarter.
      2. Number of waiver (agency) providers requesting to enroll; number requesting who met qualifications for 1915(c) waiver; number who did not meet.
      3. Number of (waiver) staff who received required trainings.

d. Consumer Direction Review:
   i. MCO will conduct a statistically valid sample on self-directed participants to insure that:
      1. Service facilitation services occurred and were properly billed
      2. Consumer-directed attendants meet requirements

3. Consumer-directed attendants are performing job duties as described.

5.42.3 Monthly reports

Requirement	Basis	Dual MA or SNP Pursuant to 42CFR 422.152 (with or without EDCD)	Dual Not enrolled in MA or SNP (with or without EDCD)	Non-dual eligible EDCD
MCOs must report all enrollee deaths to the State within ten days of the event	42CFR441.302 1915(c) waiver	X	X	X
Report of dual eligibles referred for long term care screenings (for NF and EDCD Waiver services)	42CFR441.302 1915(c) waiver	X	X	N/A
Report on claims performance	42CFR 447.45 42CFR441.302 1915(c) waiver	As available	As available	X
Provider Network to Enrollment Broker (to include LTC providers)	42CFR 438.206 42CFR 438.207	X	As available	X
Monthly report of grievances, appeals, and inquiries	42CFR 438.400	X	As available	X
Returned ID Card List	DMAS	X	X	X
Call Center Performance Report	DMAS	X	X	X

Additional Requirements for 1915(c) Waiver Compliance (EDCD participants only):

a. Report of EDCD Waiver participant hours broken down by type (respite or personal care), and further broken out by agency-directed and consumer-directed

b. Sentinel events to include report on Abuse, Exploitation, Neglect, and Serious Injury (per 1915 (c) waiver requirements), and situation resolution

c. Number of Inpatient nursing facility days

For each of the MCO reports submitted in relation to VALTC program services, DMAS QMR staff will conduct sample monitoring evaluations to assess program compliance and any potential need for corrective action plans.

5.42.4 Miscellaneous reports

a. Publicly announced acquisition contract, pre-merger contract or pre-sale contract impacting the MCO's ownership including ending affiliation with Medicaid in other states

b. Sanctions or changes in reserve requirements imposed by BOI or any other entity

c. Change in ownership

d. Copy of all oral, written, or electronic reports, presentations, or other materials, in any form, whatsoever, based in whole or in part on DMAS data. Must be reviewed and approved by DMAS prior to release to any third party.

5.42.5 Reports of critical incidents

Any suspected instances of abuse, neglect, or exploitation are required by Virginia law to be reported to the Virginia Department of Social Services. Mandated reporters must report suspected abuse, neglect and exploitation to Adult Protective Services immediately. Reports can be made through any means; there is no specified format.

Any person may voluntarily report suspected abuse, neglect, or exploitation (in various forms) to Adult Protective Services, including staff of financial institutions. Mandated reporters must report suspected abuse, neglect, and exploitation to Adult Protective Services immediately. Any person may voluntarily report suspected abuse, neglect, or exploitation to Adult Protective Services (APS) including staff of financial institutions.

The Virginia Department of Social Services receives and responds to all reports of critical incidents of abuse, neglect or exploitation. Reports are investigated by assigned DSS staff members who must initiate an investigation within 24 hours of report receipt. Investigations are finalized and closed as soon as possible given the nature and extent of the complaint. The complainant, if a mandatory reporter, is informed of the investigation disposition (founded or unfounded) at case closure.

DMAS will receive quarterly reports on APS investigations of critical incidents and events from the Virginia Department of Social Services. Oversight is conducted on a quarterly basis by a Quality Review Team in the Division of Long Term Care at DMAS.

Other critical events, such as medication errors or falls, shall be managed and monitored by the MCO and reported as required to the appropriate oversight/regulatory authority. Per 1915(b) waiver authority, patterns of critical events will be reported to DMAS on a quarterly basis to DMAS staff and the EQRO. The MCO will provide quarterly reports of critical events/incidents to DMAS in accordance with the CMS quality assurance requirements. Information will include the incident that occurred and the outcomes/resolution for each incident.

5.43 Audited Financial Statements and Income Statements

The MCO shall provide to the Department copies of its annual audited financial (or fiscal) statements no later than ninety (90) calendar days after the end of the calendar year and Quarterly Income Statements no later than thirty (30) calendar days after the end of each calendar quarter, including reports required by the Bureau of Insurance.

The Department reserves the right to require the MCO to engage the services of an outside independent auditor to conduct a general audit of the MCO's major managed care functions performed on behalf of the Commonwealth. The MCO shall provide the Department a copy of such an audit within thirty (30) calendar days of completion of the audit.

5.43.1 Public filings

The MCO shall promptly furnish the Department with copies of all public filings, including correspondence, documents and all attachments on any matter arising out of this contract.

5.43.2 Appeals reports

The MCO shall provide reconsideration and appeal logs and outcome reports as described in this contract.

5.44 Conflict Of Interest

Nothing in this contract shall be construed to prevent the MCO from engaging in activities unrelated to this Contract, including the provision of health services to persons other than those covered under this contract, provided, however, that the MCO furnishes the Department with full prior disclosure of such other activities.

5.45 Non-Discrimination

The MCO shall comply with all applicable Federal and State laws relating to non-discrimination and equal employment opportunity and assure physical and program accessibility of all services to individuals with disabilities pursuant to §504 of the Federal Rehabilitation Act of 1973, as amended (29 U.S.C. 794), and with all requirements imposed by applicable regulations in 45 C.F.R. Part 84, Title VI of the Civil Rights Act, the Americans with Disabilities Act, the Age Discrimination and Employment Act of 1967, and the Age Discrimination Act of 1975. In connection with the performance of work under this contract, the MCO agrees not to discriminate against any employee or applicant for employment because of age, race, religion, color, handicap, sex, physical condition, developmental disability or national origin. The MCO shall comply with the provisions of Executive Order 11246, "Equal Employment Opportunity," as amended by Executive Order 11375 and supplemented in the United States Department of Labor regulations (41 C.F.R. 60).

The MCO agrees to post in conspicuous places, available for employees and applicants for employment, notices to be provided by the MCO setting forth the provisions of the non-discrimination clause.

5.46 Compliance with Applicable Laws and Regulations

The MCO shall observe and comply with all Federal [(including the Health Insurance Portability and Accountability Act of 1996 (HIPAA)] and State laws and regulations in effect when the contract is signed or which may come into effect during the term of the Contract which in any manner affect the MCO's performance under this contract. In case of contract disputes, these documents will be reviewed and considered in the order shown to resolve said disputes:

i. Federal Regulations
ii. Virginia State Plan
iii. VALTC Waiver – 1915(b) and 1915(c)
iv. VALTC State Regulations
v. VALTC Contract, including all amendments, attachments, and Medicaid memos and manuals.

Any ambiguity in the interpretation of this contract shall be resolved in accordance with the requirements of Federal and Virginia laws and regulations, including the State Plan for Medical Assistance Services and Department memos, notices, and provider manuals.

Services listed as covered in any evidence of coverage or any enrollee handbook shall not take precedence over the services required under this contract or the State Plan for Medical Assistance.

5.47 Readiness for Implementation, and Implementation

5.47.1 Readiness for implementation

No later than 120 days prior to the implementation of the program start date of February 1, 2009, the MCO shall demonstrate, to the Department's satisfaction, that MCO is fully capable of performing all duties under this contract. The MCO shall be responsible for participating in and defining the details of

the Operational Readiness Assessment Plan for its service package and will be responsible for preparing and submitting its Operational Readiness Assessment Plan to the State for review and approval. The State may include providers in the operational readiness assessment. Provider participation could include providing sample prior authorization requests and other documents to be processed by the MCO, initiating telephone calls or web based direct data entry requesting information, or providing written correspondence for processing.

Any changes required to the MCO's processes as identified through readiness review activities shall be made by the MCO prior to implementation. Costs associated with these changes shall be borne by the MCO. The MCO's inability to demonstrate, to the Department's satisfaction and as provided in this Section, that MCO is fully capable of performing all duties under this contract no later than 60 prior to implementation shall be grounds for the immediate termination of the contract by the Department pursuant to the Department Special Terms and Conditions, Section 11.7 Cancellation of Contract rights.

5.47.2 Implementation

The Department will determine network adequacy based on specific utilization for the designated areas not later than 120 days prior to the planned implementation date. The MCO must meet any network requirements established by the Department. The MCO shall demonstrate adaptability to the special requirements of certain populations. The final MCO network must be submitted before pre-assignment deadlines established by the Department.

The MCO must provide written assurances that it will accept VALTC enrollees, will submit to an operational readiness review, and will adhere to the all requirements of the contract (including reporting).

6. PAYMENTS TO THE MCO

Payment processes described in this Section must be tested as part of the readiness for implementation review described in Section 5.47. Any changes required to the MCO's processes as identified through readiness review activities shall be made by the MCO prior to implementation. Costs associated with these changes shall be borne by the MCO.

The Department shall issue capitation payments on behalf of enrollees at the rates established in this contract and modified during the contract renewal process. The MCO shall accept the annually established capitation rate paid each month by the Department as payment in full for all services to be provided pursuant to this contract and all administrative costs associated therewith, pending final recoupments, reconciliation, or sanctions. Any and all costs incurred by the MCO in excess of the capitation payment shall be borne in full by the MCO. The MCO shall accept the Department's electronic transfer of funds to receive capitation payments.

6.1 Reinsurance

The MCO shall obtain reinsurance from an insurer other than the Department for coverage of enrollees under this contract.

6.2 Recoupment/Reconciliation

The Department shall recoup an enrollee's capitation payment for a given month in cases in which an enrollee's exclusion or disenrollment was effective retroactively. The Department shall not recoup an enrollee's capitation payment for a given month in cases in which an enrollee is eligible for any portion of the month.

This provision applies to cases where the eligibility or exclusion can occur throughout the month including but not limited to: death of an enrollee, cessation of Medicaid eligibility, inpatient admission to a State mental hospital, approval for HCBS waivered services other than the EDCD waiver, or hospice. This provision does not apply in cases where the Department is responsible for the total cost of medical care in a given month, e.g., hospitalization at the time of enrollment, ninth month and third trimester pregnancy exclusions, etc. In these cases the total capitation payment for the month will be rescinded.
The Department shall recoup capitation payments made in error by the Department.

When membership is disputed between two Contractors, the Department shall be the final arbitrator of MCO enrollment and reserves the right to recoup an inappropriate capitation payment.

The MCO shall not be liable for the payment of any services covered under this contract rendered to an enrollee after the effective date of the enrollee's disenrollment.

If this contract is terminated, recoupments shall be handled through a payment by the MCO within thirty (30) calendar days after contract termination or thirty (30) calendar days following determination of specific recoupment requirements, whichever comes last.

The Department shall reconcile payments on a quarterly basis. Included in the quarterly reconciliation shall be a reduction in capitation payments to account for nursing facility days, additional payments for newborns enrolling with the MCO, and other adjustments that may be required in accordance with the terms of this agreement. This reconciliation shall be based on adjustments known to be needed through the end of the quarter. If reconciliation withholdings exceed reconciliation payments, the Department may, at its option, withhold from subsequent monthly payments or bill the MCO for the difference, in

which case the MCO shall provide payment within thirty (30) calendar days of the bill date. Payments shall not be made for periods greater than twenty-four (24) months prior to the date of reconciliation. The Department has devised the following schedule for timely submission of payment for newborns.

Babies Born in:	For whom the MCO has not received payment by:	Should be reported to the Department by:
Jan, Feb, and Mar	September 15	October 1
Apr, May, and June	December 15	January 1

6.3 Federally Qualified Health Centers (FQHC) & Rural Health Clinics (RHC)

Prior to FQHC or RHC contract signature, the MCO must notify the Department of the type of financial arrangements negotiated with FQHCs or RHCs. The MCO must establish the following type of contractual arrangement:

i. If the FQHC or RHC accepts partial capitation or another method of payment at less than full risk for patient care (i.e., primary care capitation, fee-for-service), the Department will provide a cost settlement to the FQHC or RHC so that the FQHC or RHC is paid the maximum allowable of reasonable costs.
ii. In this instance, the Department shall cover the difference between the amount of direct reimbursement paid to the FQHC or RHC by the MCO and the FQHC's or RHC's reasonable costs for services provided to MCO patients. This arrangement applies only to patient care costs of VALTC enrollees.
iii. The MCO must provide assurances that it is paying the FQHC or RHC at a rate that is comparable to the rate it is paying other providers of similar services, and the MCO shall provide supporting documentation at the Department's request.

Within ten (10) business days of establishing or changing such an arrangement, the MCO shall notify the Department in writing about the type of arrangement it has established.

6.4 Billing Enrollees for Medically Necessary Services

The MCO and its subcontractors are subject to criminal penalties if providers knowingly and willfully charge, for any service provided to a recipient under the State Plan or under this contract, money or other consideration at a rate in excess of the rate established by the Department, as specified in Section 1128B(d)(1) of the Social Security Act (42 U.S.C. § 1320a-7b), as amended. This provision shall continue to be in effect even if the MCO becomes insolvent until such time as enrollees are withdrawn from assignment to the MCO.

Pursuant to Section 1932(b)(6), (42 U.S.C. § 1396u-2 (b)(6)), the MCO and all of its subcontractors shall not hold a recipient liable for:

i. Debts of the MCO in the event of the MCO's insolvency;
ii. Payment for services provided by the MCO if the MCO has not received payment from the Department for the services or if the provider, under contract or other arrangement with the MCO, fails to receive payment from the Department or the MCO; or
iii. Payments to providers that furnish covered services under a contract or other arrangement with the MCO that are in excess of the amount that normally would be paid by the recipient if the service had been received directly from the MCO.

6.4.1 Billing enrollees for other services

The MCO, including its network providers and subcontractors, shall not bill an enrollee for any services provided under this contract. The MCO shall assure that all in network provider contracts include requirements whereby the enrollee shall be held harmless for charges for any Medicaid covered service. This includes those circumstances where the provider fails to obtain necessary referrals, preauthorization, or fails to perform other required administrative functions. However, if an enrollee agrees in advance of receiving the service and in writing to pay for a service that is not a State Plan covered service, then the MCO, directly or through its network provider or subcontractor can bill the enrollee for the service.

6.5 Payment using DRG methodology

If the MCO has a contract with a facility to reimburse the facility for services rendered to its members based on a Diagnosis Relative Grouping (DRG) payment methodology, the MCO shall be responsible for the full inpatient hospitalization from admission to discharge. This will be effective for any member who is actively enrolled in the MCO on the date of admission regardless if the member is disenrolled from the MCO during the course of the inpatient hospitalization.

6.6 Payments for Newborns

Until such time that a newborn is assigned a Medicaid identification number, the charges for newborns to mothers enrolled with the MCO are the responsibility of the MCO. Where enrollment errors occur that are later corrected, regardless of the time frame to correct such error, the MCO is required to cover the newborn recipient and related charges. The Department will reimburse the MCO the appropriate capitation payment.

6.7 Third-Party Liability (TPL)

6.7.1 Comprehensive health coverage

Individuals enrolled in Medicaid, determined by the Department as having comprehensive health coverage (excluding full benefit dual eligibles) will be assigned to the fee-for-service program, effective the first day of the month following the month in which the coverage was verified. Members will not be retroactively disenrolled due to comprehensive health coverage. Until disenrollment occurs, the MCO shall be responsible for coordinating all benefits and following Medicaid "payer of last resort" rules. This means that deductibles and coinsurance are covered by the MCO up to the maximum reimbursement amount that would have been paid in the absence of other primary insurance coverage.

Under Section 1902 (a)(25) of the Social Security Act (42 U.S.C. §1396 a (a)(25)), the State is required to take all reasonable measures to identify legally liable third parties and pursue verified resources. In cases in which the recipient was not identified for exclusion prior to enrollment in the MCO, the MCO shall take responsibility for identifying and pursuing comprehensive health coverage. Any moneys recovered by third parties shall be retained by the MCO and identified monthly to the Department. The MCO shall notify DMAS on a monthly basis of any enrollees identified during that past month who were discovered to have comprehensive health coverage.

6.7.2 Workers' compensation

If a member is injured at his or her place of employment and files a workers' compensation claim, the MCO shall remain responsible for all services. The MCO may seek recoveries from a claim covered by workers' compensation if the MCO actually reimbursed providers and the claim is approved for the workers' compensation fund. The MCO shall notify DMAS on a monthly basis of any enrollees identified during that past month who are discovered to have workers' compensation coverage.
If the member's injury is determined not to qualify as a worker's compensation claim, the MCO shall be responsible for all services provided while the injury was under review, even if the services were provided by out-of-network providers, in accordance with worker's compensation regulations.

6.7.3 Estate recoveries

The MCO is prohibited from collecting estate recoveries. The MCO shall notify DMAS on a monthly basis of any enrollees identified during that past month who have died and are over the age of 55.

6.7.4 Other coverage

The Department retains the responsibility to pursue, collect, and retain all non-health insurance resources such as casualty, liability, estates, child support, and personal injury claims. The MCO is not permitted to seek recovery of any non-health insurance funds.

Individuals with these other resources shall remain enrolled in the MCO. The MCO shall notify DMAS on a monthly basis of any enrollees identified during that past month who are discovered to have any of the above coverage, including enrollees identified as having trauma injuries. The MCO shall provide DMAS with all encounter/claims data associated with care given to recipients who have been identified as having any of the above coverage.

7. REMEDIES FOR VIOLATION, BREACH, OR NON-PERFORMANCE OF CONTRACT

Upon receipt by the Department of evidence of substantial non-compliance by the MCO with any of the provisions of this contract or with State or federal laws or regulations including, but not limited to, the requirements of or pursuant to 12VAC30-121-850, as amended, the following remedies may be imposed.

7.1 Prohibition Against Contracting With Excluded Providers

The MCO (which shall include its subcontractors) shall ensure that providers in their networks are licensed by the State and have received proper certification or training to perform the specific services for which they are contracted. Network providers must also be in good standing with the Department programs or applicable licensing board.

In accordance with 1902(a)(39) and (41), 1128, and 1128A of the Social Security Act, 42 CFR § 438-610, 42 CFR §1002, and 12VAC30-10-690 of the Virginia Administrative Code and other applicable federal and state statutes and regulations, the MCO shall neither participate with nor enter into any provider contract with any individual or entity that has been excluded from participation in federal health care programs.

Federal health care programs include Medicare, Medicaid, and all other plans and programs that provide health benefits funded directly or indirectly by the United States. A searchable database of persons excluded from participation can be found at www.oig.hhs.gov/fraud/exclusions/listofexcluded.html

The MCO is prohibited from contracting with providers who have been terminated from the Medicaid programs by DMAS for fraud and abuse.

The MCO's standards for licensure and certification shall be included in its participating provider network contracts.

The MCO shall have written policies and procedures for their provider enrollment and/or credentialing process. The MCO shall perform, at a minimum, an annual review on all providers to ensure that their contracted health care professionals have not been included on the federal database of excluded providers.

The MCO shall have in place a mechanism for reporting to the Department and any appropriate authorities all actions that seriously impact quality of care and which may result in suspension or termination of a practitioner's license. The MCO also shall report to the Department within five business days of discovery of any network providers that have been identified on the federal database of excluded providers and the action taken by the MCO. The MCO shall submit a copy of the policies and procedures to the Department annually or in the event of any modifications to the process or standards.

7.2 For MCO Non-Compliance Notification

In the event that the Department identifies or learns of noncompliance with the terms of this contract, the Department will notify the MCO in writing of the nature of the noncompliance. The MCO shall remedy the noncompliance within a time period established by the Department, and the Department will designate a period of time, not less than ten (10) calendar days, in which the MCO must provide a written response to the notification. The Department may develop or may require the MCO to develop procedures with which the MCO must comply to eliminate or prevent the imposition of specific remedies.

7.3 Specific Compliance Emphasis

While the Department requires strict compliance with all contract provisions, it places particular emphasis on prompt, accurate, and complete compliance with requirements related to the following:

i. access to medical services;
ii. quality;
iii. network access;
iv. marketing activities;
v. issuance of enrollee ID cards;
vi. submission of encounter data;
vii. submission of requested medical records;
viii. submission of required reports; and
ix. abuse

Contractors may expect the prompt imposition of stringent remedies for failure to comply with contract requirements associated with failure to comply with contract requirements associated with these priority items.

7.4 Remedies Available to the Department

The Department reserves the right to employ, at the Department's sole discretion, any of the remedies and sanctions set forth below and to resort to other remedies provided by law. In no event may the application of any of the following remedies preclude the Department's right to any other remedy available in law or regulation.

7.4.1 Remedies

In the event of any breach of the terms of the contract by the MCO, the MCO shall pay damages to the Department for such breach at the sole discretion of the Department, at a minimum, according to the following subsections.

If, in a particular instance, the Department elects not to exercise a damage clause or other remedy contained herein, this decision shall not be construed as a waiver of the Department's right to pursue future assessment of that performance requirement and associated damages, including damages that, under the terms of the contract, may be retroactively assessed.

a. Federally-Prescribed Sanctions For Noncompliance
    i. Section 1932(e)(1)(A) of the Social Security Act (the Act) describes the use of intermediate sanctions for States. Such sanctions may include any of the ones described in subparagraph C.1.a.ii through C.1.a.vii below, and may be imposed if the managed care organization:
        1. fails to substantially provide medically necessary items and services that are required (under law or under such organization's contract with the State) to be provided to an enrollee covered under the contract;
        2. imposes premiums or charges enrollees in excess of the premiums or charges permitted under Title XIX of the Act;
        3. acts to discriminate among enrollees on the basis of their health status or requirements for health care services, including expulsion or refusal to re-enroll an individual, except as permitted by Title XIX of the Act, or engaging in any practice that would reasonably be expected to have the effect of denying or discouraging

enrollment with the entity by eligible individuals whose medical condition or history indicates a need for substantial future medical services.

4. fails to comply with the physician incentive requirements under section 1903(m)(2)(A)(x) of the Act. In addition, the State may impose sanctions against a managed care entity if the State determines that the entity distributed directly, or through any agent or independent MCO marketing materials that contain false or misleading information.

ii. Section 1932(e)(2)(A) of the Act allows the State to impose the following civil money penalties:

1. For each determination that the managed care organization (MCO) fails to substantially provide medically necessary services or fails to comply with the physician incentive plan requirements, a maximum of $25,000.
2. For each determination that the MCO discriminates among enrollees on the basis of their health status or requirements for health care services or engages in any practice that has the effect of denying or discouraging enrollment with the entity by eligible individuals based on their medical condition or history that indicates a need for substantial future medical services, or the MCO misrepresents or falsifies information furnished to the Secretary of Health and Human Services, State, enrollee, potential enrollee, or health care provider, a maximum of $100,000.
3. For each determination that the MCO has discriminated among enrollees or engaged in any practice that has denied or discouraged enrollment, the money penalty may be as high as $15,000 for each individual not enrolled as a result of the practice, up to a maximum of $100,000.
4. With respect to a determination that the MCO has imposed premiums or charges on enrollees in excess of the premiums or charges permitted, the money penalty may be a maximum of $25,000 or double the amount of the excess charges, whichever is greater. The excess amount charged must be deducted from the penalty and returned to the enrollee concerned.

iii. Section 1932(e)(2)(B) of the Act specifies the conditions for appointment of temporary management:

1. Temporary management is imposed if the State finds that there is continued egregious behavior by the MCO or there is substantial risk to the health of the enrollees. Temporary management may also be imposed if there is a need to assure the health of the organization's enrollees during an orderly termination or reorganization of the MCO or while improvements are made to correct violations.
2. Once temporary management is appointed, it may not be removed until it is determined that the organization has the capability to ensure that the violations will not recur.

iv. Sections 1932(e)(2)(C), (D), and (E) of the Act describe other sanctions that may be imposed:

1. The State may permit individuals enrolled in a managed care entity to disenroll without cause.
2. The State may suspend or default all enrollment of Medicaid beneficiaries after the date the Secretary of Health and Human Services or the State notifies the entity of a violation determination under Section 1903(m) or Section 1932(e) of the Act.
3. The State may suspend payment to the entity under Title XIX for individual enrollees after the date the Secretary of Health and Human Services or the State notifies the

entity of the determination and until the entity has satisfied the Secretary or the State that the basis for such determination has been corrected and will not likely recur.

v. Section 1932(e)(3) of the Act specifies that if an MCO has repeatedly failed to meet the requirements of Section 1903(m) or Section 1932(e) of the Act, the State must (regardless of what other sanctions are provided) impose temporary management and allow individuals to disenroll without cause.

vi. Section 1932(e)(4) of the Act allows the State to terminate contracts of any managed care entity that has failed to meet the requirements of Section 1903(m), 1905(t)(3), or 1932(e) of the Act and enroll the entity's enrollees with other managed care entities or allow enrollees to receive medical assistance under the State Plan other than through a managed care entity.

vii. Title 42 CFR § 438.730 allows the State to recommend that CMS impose the denial of payment sanction for new enrollees of the managed care organization when, and for so long as, payment for those enrollees is denied by CMS in accordance with the requirements set forth in 42 CFR 438.730.

viii. The State must give the managed care entity a hearing before termination occurs, and the State must notify the individuals enrolled with the managed care entity of the hearing and allow the enrollees to disenroll if they choose without cause.

b. Other Specified Sanctions

If the Department determines that the MCO failed to provide one (1) or more of the services required under the contract, or that the MCO failed to maintain or make available any records or reports required under the contract by the Department which the Department may use to determine whether the MCO is providing services as required, or if the Department finds that the MCO is not in compliance with the terms of its contracts with other providers, contractors or sub-contractors, or if the Department determines that the MCO is acting in a manner which delays or impedes any enrollee's ability to seek care and threatens the well-being of the enrollee within a reasonable time frame, or if another state takes punitive action against the MCO based on findings of wrongdoing within that state's Medicaid program, the Department may enforce sanctions upon the MCO and the following remedies may be imposed:

i. Suspensions of New Enrollment

The Department may suspend the MCO's right to enroll new Medicaid participants (voluntary, automatically assigned, or both) under this contract. The Department may make this remedy applicable to specific populations served by the MCO or the entire contracted area. The Department, when exercising this option, must notify the MCO in writing of its intent to suspend new Medicaid enrollment at least thirty (30) calendar days prior to the beginning of the suspension period. The suspension period may be for any length of time specified by the Department, or it may be indefinite. The Department may also suspend new Medicaid enrollment or disenroll Medicaid recipients in anticipation of the MCO not being able to comply with any requirement of this Contract or with federal or State laws or regulations at its current enrollment level. Such suspension shall not be subject to the thirty (30) calendar day notification requirement.

The Department may also notify enrollees of MCO non-compliance and provide such enrollees an opportunity to enroll with another MCO.

ii. Department-Initiated Disenrollment
The Department may reduce the number of current enrollees by disenrolling the MCO's Medicaid enrollees. The MCO shall be given at least thirty (30) calendar days notice prior to the Department taking any action set forth in this paragraph.

iii. Reduction in Maximum Enrollment Cap
The Department may reduce the maximum enrollment level or number of current Medicaid enrollees. The MCO shall be given at least thirty (30) calendar days notice prior to the Department taking any action set forth in this paragraph.

iv. Suspension of Marketing Services and Activities
The Department may suspend a MCO's marketing activities which are geared toward potential enrollees. The MCO shall be given at least ten (10) calendar days notice prior to the Department taking any action set forth in this paragraph.

v. Financial Sanctions
The Department may impose financial sanctions/penalties upon the MCO of at least the amount of payment required in the MCO's contract with the disputing party.

c. Withholding of Capitation Payments and Recovery of Damage Costs

i. When the Department withholds payments under this section, the Department must submit to the MCO a list of the members for whom payments are being withheld, the nature of the services denied, and payments the Department must make to provide medically necessary services. In any case under this contract where the Department has the authority to withhold capitation payments, the Department also has the authority to use all other legal processes for the recovery of damages. The Department may withhold portions of capitation payments or otherwise recover damages from the MCO in the following situations.

Whenever the Department determines the MCO failed to provide one (1) or more of the medically necessary VALTC covered services, the Department may direct the MCO to provide such service or withhold a portion of the MCO's capitation payments for the following month or subsequent months, such portion withheld to be equal to the amount of money the Department must pay to provide such services. The MCO shall be given at least seven (7) calendar days written notice prior to the withholding of any capitation payment.

ii. Whenever the Department determines that the MCO has failed to perform an administrative function required under the contract, the Department may withhold a portion of future capitation payments to compensate for the damages which this failure entails. For the purposes of this section, "administrative function" is defined as any service.

iii. In any case where the Department intends to withhold capitation payments or recover damages through the exercise of other legal processes, the following procedures shall be used:
1. The Department shall notify the MCO of the MCO's failure to perform required administrative functions under the contract.
2. The Department shall give the MCO thirty (30) calendar days notice to develop an acceptable plan for correcting this failure.

3. If the MCO has not submitted an acceptable correction action plan within thirty (30) calendar days, or has not implemented this plan within the timeframe in the approved action plan, the Department will provide the MCO with a written document itemizing the damage costs for which it intends to require compensation seven (7) calendar days prior to withholding any capitation payment. The Department shall then proceed to recover said compensation.
4. The Department shall notify the MCO when it is determined that the MCO is not in compliance with a provision in this contract. Notice shall be sent requesting a corrective action plan to resolve the error. If the MCO fails to respond to the Department's request in three (3) business days, the Department shall notify the MCO in writing of its failure to respond to the Department is a violation of this contract. If the MCO continues to withhold corrective action within one (1) week of the date of the letter, the Department's Director shall notify the MCO that its continued failure to act will result in one or a combination of the following remedies to the Department:
   a) withhold of capitation;
   b) withhold/suspension of future enrollment;
   c) fines for violation not to exceed $10,000 per occurrence; and/or termination of the contract.

d. Probation

The Department may place a MCO on probation, in whole or in part, if the Department determines that it is in the best interest of Medicaid recipients and the Department. The Department may do so by providing the MCO with a written notice explaining the terms and the time period of the probation. The MCO shall, immediately upon receipt of such notice, provide services in accordance with the terms set forth and shall continue to do so for the period specified or until further notice. When on probation, the MCO shall work in cooperation with the Department, and the Department may institute ongoing review and approval of MCO Medicaid activities.

e. Suspension of MCO Operations

The Department may suspend a MCO's VALTC operations, in whole or in part, if the Department determines that it is in the best interest of VALTC recipients to do so. The Department may do so by providing the MCO with written notice. The MCO shall, immediately upon receipt of such notice, cease providing services for the period specified in such notice, or until further notice.

f. Remedial Actions

The Department may pursue all remedial actions with the MCO that are taken with Medicaid fee-for-service providers. The Department will work with the MCO, and the MCO's network providers to change and correct problems and will recoup funds if the MCO fails to correct a problem within a timely manner.

g. Remedies Not Exclusive

The remedies available to the Department as set forth above are in addition to all other remedies available to the Department in law or in equity, are joint and severable, and may be exercised concurrently or consecutively. Exercise of any remedy in whole or in part shall not limit the Department in exercising all or part of any other remedies.

7.5 Appeal Rights of the MCO

For violations set forth in both 42 C.F.R. 434.67 (a) and 12VAC30-121-85, the Department may impose the sanctions provided therein.

The Department shall follow the procedures set forth in 12VAC30-121-85 and C.F.R. 42 434.67 (a) allowing them to impose the sanctions provided therein.

The MCO shall have all the appeal rights provided for in 42 C.F.R. 434.67 (a) and 12VAC30-121-85.

For all other sanctions the MCO shall have the appeal rights provided for in the Virginia Public Procurement Act, 11-35 et. seq. of the Code of Virginia.

7.6 Attorney Fees

In the event the Department shall prevail in any legal action arising out of the performance or non-performance of this contract, the MCO shall pay, in addition to any damages, all expenses of such action including reasonable attorney's fees and costs. The term "legal action" shall be deemed to include administrative proceedings of all kinds, as well as all actions at law or equity.

7.7 Disputes

7.7.1 Right to appeals

The MCO shall have the right to appeal any adverse action taken by the Department. All appeals arising out of a sanction or remedy levied pursuant to Section 7 of this contract shall be handled in accordance with Section 7.

For appeals not addressed by Section 7, the MCO shall proceed in accordance with the appeals provisions in the Code of Virginia, § 11-35, as amended, et seq. (the Virginia Public Procurement Act). Pursuant to the Code of Virginia §§ 11-70 and 11-71, as amended, the Department establishes an administrative appeals procedure under which the MCO may elect to appeal decisions on disputes arising during the performance of its contract. In conducting the administrative appeal, the hearing officer shall follow the hearing procedure like that in Code of Virginia § 2.2-4020, as amended.

The MCO may not submit to the Department for resolution under this section disputes relating to Medicaid eligibility requirements or VALTC covered services.

7.7.2 Disputes arising out of the contract

As provided for in Code of Virginia § 11-69, as amended, disputes arising out of the contract, whether for money or other relief, are to be submitted by the MCO for consideration by the Department. Disputes must be submitted in writing, with all necessary data and information, to the Contract Administrator or designee.

Disputes will not be considered if submitted later than sixty (60) calendar days after the date on which the MCO knew of the occurrence giving rise to the dispute or the beginning date of the work upon which the dispute is based, whichever is earlier. Further, no claim may be submitted unless written notice of the MCO's intention to file the dispute has been submitted at least thirty (30) calendar days prior to a formal filing of the dispute, and such thirty (30) calendar days is to be counted from the date of the occurrence or the beginning date of the work upon which the dispute is based, whichever is earlier.

7.7.3 Informal resolution of disputes arising out of the contract

For any dispute arising out of the contract, except for any dispute resulting from any breach of statute or regulation, the parties shall first attempt to resolve their differences informally. Should the parties fail to resolve their differences after good-faith efforts to do so, then the parties may proceed with formal avenues for resolution of the dispute.

7.7.4 Presentation of documented evidence

The MCO is obligated to present to the Department all witnesses, documents, or other evidence necessary to support its claim. Evidence that the MCO has but fails to present to the Department will be deemed waived and may not be presented to the Circuit Court.
The MCO shall have the burden of proving to the Department by a preponderance of the evidence that the relief it seeks should be granted.

7.8 Omissions

In the event that either party hereto discovers any material omission in the provisions of this contract which such party believes is essential to the successful performance of this contract, said party may so inform the other party in writing, and the parties hereto shall thereafter promptly negotiate in good faith with respect to such matters for the purpose of making such reasonable adjustments as may be necessary to perform the objectives of this contract.

7.9 Waiver

No delay or failure by either party hereto to exercise any right or power accruing upon noncompliance or default by the other party with respect to any of the items of this contract shall impair such right or power or be construed to be a waiver thereof. A waiver by either of the parties hereto of a breach of any of the covenants, conditions, or contracts to be performed by the other shall not be construed to be a waiver of any succeeding breach thereof or of any other covenant, condition, or contract herein contained.

7.10 Severability

If any provision of this contract is declared or found to be illegal, unenforceable, invalid or void, then both parties shall be relieved of all obligations arising under such provision; but if such provision does not relate to payments or services to enrollees and if the remainder of this contract shall not be affected by such declaration or finding, then each provision not so affected shall be enforced to the fullest extent permitted by law.

7.11 Assignability

Except as allowed under subcontracting, the contract is not assignable by the MCO, either in whole or in part, without the prior written consent of the Department.

7.12 Right to Publish

The Department agrees to allow the MCO to write on subjects associated with the work under this contract and have such writing published, provided the MCO receives prior written approval from the Department before publishing such writings.

7.13 Covenant Against Contingent Fees

The MCO shall warrant that no person or selling agency has been employed or retained to solicit and secure the VALTC contract upon a contract or understanding for commission, percentage, brokerage, or contingency, excepting bona fide employees or selling agents maintained by the MCO for the purpose of securing the business. For breach or violation of this warranty, the Commonwealth of Virginia shall have the right to cancel the contract without liability or in its discretion, to deduct from the contract price or to otherwise recover the full amount of such commission, percentage, brokerage, or contingency.

7.14 Delivery Dates for Information Required By the Department

When the last day for submission of any required information or reports to the Department by the MCO falls on a Saturday, Sunday or legal holiday, the information may be delivered on the next day that is not a Saturday, Sunday or legal holiday.

7.15 HIPAA Disclaimer

The Department makes no warranty or representation that compliance by the MCO with this contract or the HIPAA regulations will be adequate or satisfactory for the MCO's own purposes or that any information in the MCO's possession or control, or transmitted or received by the MCO, is or will be secure from unauthorized use or disclosure, nor shall the Department be liable to the MCO for any claim, loss or damage related to the unauthorized use or disclosure of any information received by the contractor from the Department or from any other source. The MCO is solely responsible for all decisions made by the MCO regarding the safeguarding of PHI.

8. APPLICATION PREPARATION AND SUBMISSION REQUIREMENTS

Each MCO shall submit a Mandatory Requirements Application on May 30, 2008 and an Application for Covered Services on August 29, 2008 in relation to the requirements described in this contract. The following describes the general requirements for each application.

General Requirements for Applications

8.1 Overview

The Applications shall be developed and submitted in accordance with the instructions outlined in this section. The MCO's applications shall be prepared simply and economically, and they shall include a straightforward, concise description of the MCO's capabilities that satisfy the requirements of the contract. Although concise, the applications should be thorough and detailed so that DMAS may properly evaluate the MCO's capacity to provide the required services. All descriptions of services should include an explanation of proposed methodology, where applicable. The applications may include additional information that the MCO considers relevant to this contract.

The applications shall be organized in the order specified in this contract. Failure to provide information required by this contract may result in rejection of the application.

8.2 Binding of Application

The Mandatory Requirements Application and Contract for Services Application shall be clearly labeled on the front cover. The legal name of the organization submitting the application shall also appear on the covers of the both applications.

The applications shall be typed, bound, page-numbered, single-spaced with a 12-point font on 8 1/2" x 11" paper with 1" margins and printed on one side only. Each copy and all documentation submitted shall be contained in single three-ring binder volumes where practical. A tab sheet keyed to the Table of Contents shall separate each major section. The title of each major section shall appear on the tab sheet.

The MCO shall submit an original and ten (10) copies of both applications by the response date and time specified in this contract. Each copy of the application shall be bound separately. This submission shall be in a sealed envelope or sealed box clearly marked. The MCO shall also submit one electronic copy (compact disc preferred) of their Mandatory and Covered Services Application in MS Word format (Microsoft Word 2000 or compatible format). In addition, the MCO shall submit a redacted (proprietary and confidential information removed) electronic copy of their Mandatory and Contract for Services Applications.

8.3 Table of Contents

The applications shall contain a Table of Contents that cross-references the contract submittal requirements. Each section of the applications shall be cross-referenced to the appropriate section of the contract that is being addressed. This will assist DMAS in determining uniform compliance with specific contract requirements.

8.4 Submission Requirements

All information requested in this contract shall be submitted in the MCO's applications. By submitting an application, the MCO certifies that all of the information provided is true and accurate.

All data, materials and documentation originated and prepared for the Commonwealth pursuant to this contract belong exclusively to the Commonwealth and shall be subject to public inspection in accordance with the Virginia Freedom of Information Act. Confidential information shall be clearly marked in the application and reasons the information should be confidential shall be clearly stated.

Trade secrets or proprietary information submitted by an MCO are not subject to public disclosure under the Virginia Freedom of Information Act; however, the MCO shall invoke the protections of §2.2-4342(F) of the Code of Virginia, in writing, either before or at the time the data is submitted. The written notice shall specifically identify the data or materials to be protected and state the reasons why protection is necessary.

The proprietary or trade secret materials submitted shall be identified by some distinct method such as highlighting or underlining and shall indicate only the specific words, figures, or paragraphs that constitute trade secret or proprietary information. The classification of an entire application document, line item prices and/or total application prices as proprietary or trade secrets is not acceptable and, in the sole discretion of DMAS, may result in rejection and return of the application.

All information requested by this contract on ownership, utilization and planned involvement of small businesses, women-owned businesses and minority-owned business shall be submitted with the Covered Services Application.

8.5 Transmittal Letter

The transmittal letter shall be on official organization letterhead and signed by the individual authorized to legally bind the MCO to contracts and the terms and conditions contained in this contract. The organization official who signs the application transmittal letter shall be the same person who signs the cover page of the contract and Addenda.

At a minimum, the transmittal letter shall contain the following:

1. A statement that the MCO meets the required conditions to be an eligible candidate for the contract award including:
   a) The MCO must identify any contracts or contracts they have with any state or local government entity that is a Medicaid provider or MCO and the general circumstances of the contract or contract. This information will be reviewed by DMAS to ensure there are no potential conflicts of interest;
   b) MCO must be able to present sufficient assurances to the state that the award of the contract with the MCO will not create a conflict of interest between the MCO, the Department, and its subcontractors; and
   c) The MCO must be licensed to conduct business in the state of Virginia.

2. A statement that the MCO has read, understands and agrees to perform all of the MCO responsibilities and comply with all of the requirements and terms set forth in this contract, any modifications of this contract, the contract and addenda;

3. The MCO's general information, including the address, telephone number, and facsimile transmission number;

4. Designation of an individual as the authorized representative of the organization who will interact with DMAS on any matters pertaining to this contract; and

5. A statement agreeing that the MCO's application shall be valid for a minimum of 180 days from its submission to DMAS.

8.6 Signed Cover Page of the Contract and Addenda

To attest to all contract terms and conditions, the authorized representative of the MCO shall sign the cover page of this contract, as well as the cover page of the Addenda, if issued, to the contract, and submit them along with its application.

8.7 Department Contact

The principal point of contact for this contract in DMAS shall be:

Suzanne Gore
VALTC Program Manager
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219
Email: ALTCMCO@dmas.virginia.gov

All communications with DMAS regarding this contract should be directed to the principal point of contact. All contract content-related questions shall be in writing to the principal point of contact.

8.8 Submission and Acceptance of Applications

The Mandatory Application, whether mailed or hand delivered, shall arrive at DMAS no later than 2:00 p.m. EST on May 30, 2008 and August 29, 2008 for the Covered Services Application. DMAS shall be the sole determining party in establishing the time of arrival of applications. Late applications shall not be accepted and shall be automatically rejected from further consideration. The address for delivery is:

Applications may be sent by US mail, Federal Express, UPS, etc. to:
Attention: Suzanne Gore
VALTC Program Manager
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, VA 23219

Hand Delivery or Courier to:
Attention: Suzanne Gore
VALTC Program Manager
Department of Medical Assistance Services
7th Floor DMAS Receptionist
600 East Broad Street
Richmond, VA 23219

If DMAS does not receive at least one responsive application as a result of this contract, DMAS reserves the right to select a MCO that best meets DMAS' needs. DMAS management shall select this MCO. DMAS also reserves the right to reject all applications. DMAS reserves the right to delay implementation of the contract if a satisfactory MCO is not identified or if DMAS determines a delay is necessary to ensure implementation goes smoothly without service interruption. Information will be posted on the DMAS web site, http://www.DMAS.virginia.gov/.

DMAS may make one or more on-site visits to see the MCO's operation of another contract. DMAS shall be solely responsible for its own expenses for travel, food and lodging.

8.9 Covered Services Application

The following describes the required format, content and sequence of presentations for the Covered Services Application due August 29, 2008:

8.9.1 Chapter One: Executive Summary

The Executive Summary Chapter shall highlight the MCO's:

i. Understanding of the project requirements.
ii. Qualifications to serve as the DMAS MCO for the project.
iii. Overall Approach to the project and a summary of the contents of the application.

8.9.2 Chapter Two: Corporate Qualifications and Experience

Chapter Two shall present the MCO's qualifications and experience to serve as the MCO. Specifically, the MCO shall describe its:

1. Organization Status:

    A. Name of Project Director for this Contract;

    B. Name, address, telephone number, fax number, and e-mail address of the legal entity with whom the contract is to be written;

    C. Federal employer ID number;

    D. Name, address, telephone numbers of principal officers (president, vice-president, treasurer, chair of the board of directors, and other executive officers);

    E. Name of the parent organization and major subsidiaries;

    F. Major business services;

    G. Legal status and whether it is a for-profit or a not-for-profit company;

    H. A list of board members and their organizational affiliations;

    I. Current organization chart; and

    J. Any specific licenses and accreditation held by the MCO.

2. Corporate Experience:

    A. MCO's overall qualifications to carry out a project of this nature and scope.

    B. The MCO shall describe the background and success of the MCO's organization and experience in performing managed care services described in this contract.

C. The MCO's knowledge of the Medicaid recipient populations and the communities.

D. For each experience with operating, managing, or contracting for the provision of managed long-term care services or other human services, the MCO shall indicate the contract or project title, dates of performance, scope and complexity of contract

E. Any other related experience the MCO feels is relevant shall be included.

F. The MCO shall indicate whether the MCO has had a contract terminated for any reason within the last five years.

G. The MCO also shall indicate if a claim was made on a payment or performance bond. If so, the MCO shall submit full details of the termination and the bonds including the other party's name, address, and telephone number.

8.9.3 Chapter Three: Tasks and Technical Approach

The MCO shall fully describe how it intends to meet all of the tasks required in the contract. DMAS does not want a "re-write" of the contract requirements. Specifically, the MCO shall describe in detail its proposed approach for each of the required tasks. This includes how each task will be performed, what problems need to be overcome, what functions the staff will perform, and what assistance will be needed from DMAS, if any.

Note: DMAS welcomes new and innovative approaches to MCO program services. While fully addressing the MCO objectives of this contract, the MCO may also include alternate approaches for DMAS consideration.

8.10 Agreement to Terms and Conditions

Through submittal of the response of the Department's contract and by signing this contract, the MCO shall accept and agree to all of the terms, conditions, criteria, and requirements set forth in these documents and their attachments. Acceptance of the terms and conditions shall serve as a waiver of any and all objections by the MCO as to the contents of the Department's contract.

The MCO may request to be exempted from any agreed upon requirement; however, such request for exemption must be requested in writing and in advance of the contract effective date. Any release by the Department of any contractual requirement must be approved by the Department's management. No approval will be granted if the request affects the delivery of covered services, access to providers, or quality of care for members.

8.11 Misrepresentation of Information

Misrepresentation of a MCO's status, experience, or capability in the performance of this contract may result in termination. Existence of known litigation or investigations in similar areas of endeavor may, at the discretion of the Department, result in immediate contract termination and/or replacement.

8.12 Contract Schedule of Events

The following contract Schedule of Events represents the State's maximum time frame that shall be followed for implementation of the program.

EVENT	DATE
State Issues Contract	April 30, 2008
Deadline for Submission of Mandatory Requirements	May 30, 2008
Contract Signed and Approved	June 20, 2008
Deadline for Submitting Final Application to the Department	August 29, 2008
Readiness Review Begins	October 1, 2008
Implementation Date	February 1, 2009

If it becomes necessary to revise any part of this contract, or if additional data is necessary for an interpretation of provisions of this contract prior to the due date for applications, an addendum will be issued to all MCO's by the Department. If supplemental releases are necessary, the Department reserves the right to extend the due dates and time for receipt of applications to accommodate such interpretations of additional data requirements. The contract and subsequent information will be listed on the Department's website at www.dmas.virginia.gov.

9. APPLICATION EVALUATIONS AND AWARD CRITERIA

DMAS will conduct a comprehensive, fair, and impartial evaluation of the Mandatory and Covered Services Applications received in response to this contract. The Evaluation Team will be responsible for the review of all applications. This group will be responsible for the recommendation to the DMAS Director.

9.1 Evaluation of Minimum Requirements

DMAS will initially determine if each Mandatory Application addresses the minimum contract requirements. Applications shall comply with the instructions to MCO's contained throughout this contract. Failure to comply with the instructions shall deem the application non-responsive and subject to disqualification without further consideration. DMAS reserves the right to waive minor irregularities.

The minimum requirements for an application to be given consideration are:

A. Contract Cover Sheet**:** This form shall be completed and properly signed by the authorized representative of the organization.

B. Closing Date: The application shall have been received, as provided in Section 8.8, before the closing of acceptance of applications in the number of copies specified.

C. Compliance: The application shall comply with the entire format requirements described in Section 4 and the Covered Services Application requirements described in Section 5.

D. Mandatory Conditions: All mandatory General and Specific Terms and Conditions contained in Section 10 and Section 11 shall be accepted.

E. SWAM Utilization: Summarize the planned utilization of DMBE certified small businesses and businesses owned by women and minorities under the contract to be awarded as a result of this solicitation. Appendix L.

F. Projected Scope of Work: All mandatory General and Specific Terms and Conditions contained in Section 10 and Section 11

9.2 Application Evaluation Criteria

The broad criteria for evaluating applications include, but are not limited to, the elements below:

A. Experience

Describe the experience of the MCO in performing required services.

- Experience of the MCO in working with indigent populations, particularly Medicaid or other healthcare populations.
- Experience of the MCO in performing services within the past year(s) most comparable to the MCO's application, to include a description of the type, size, and duration of previous experience.

B. Covered Services Application

Demonstration in the written application of the MCO's ability, facilities and capacity to provide all required services in a timely, efficient and professional manner.

- Clarity and thoroughness of the MCO's application in addressing the components of the

contract and implementing them as described and on schedule.

- Proposed project management of the resources available to the MCO for meeting the requirements of the contract.

C. Staffing

Describe the experience and expertise of specific staff assigned.

- Prior experience of staff with similar projects.
- Qualifications of staff.
- Appropriateness of the relationship between staff qualifications and assigned responsibilities.

D. SWAM Planned Utilization

9.3 Contract Award

The Department will award contracts to qualified and licensed MCOs. The Department reserves the right to conduct an on-site review to assess the readiness of the MCO to effectively administer the managed long-term care contract and to provide the managed care services defined in the contract.

At any time, the Department may terminate all activities and cancel or re-release this contract. The reasons for such termination will be documented and made part of the State file.

9.3.1 Signing and Execution of the Contract

Successful MCO's will be required to enter into a contract with the Department within seven (7) days of having received a Final contract document from the Department. If the MCO fails to enter into a contract within seven (7) days, the State may withdraw the notice and select another MCO, restart the contracting process, or discontinue the contract entirely until the date the applications are due.

10. GENERAL TERMS AND CONDITIONS

10.1 Applicable Laws and Courts

This solicitation and any resulting Contract shall be governed in all respects by the laws of the Commonwealth of Virginia and any litigation with respect thereto shall be brought in the courts of the Commonwealth. The agency and the Vendor are encouraged to resolve any issues in controversy arising from the award of the Contract or any Contract dispute using Alternative Dispute Resolution (ADR) procedures *(Code of Virginia,* §2.2-4366). ADR procedures are described in Chapter 9 of the *Vendors Manual.* The Vendor shall comply with all applicable federal, state and local laws, rules and regulations.

10.2 Anti-Discrimination

By submitting their applications, MCO's certify to the Commonwealth that they will conform to the provisions of the Federal Civil Rights Act of 1964, as amended, as well as the Virginia Fair Employment Contracting Act of 1975, as amended, where applicable, the Virginians with Disabilities Act, the Americans with Disabilities Act and any other applicable laws. If the award is made to a faith-based organization, the organization shall not discriminate against any recipient of goods, services, or disbursements made pursuant to the contract on the basis of the recipient's religion, religious belief, refusal to participate in a religious practice, or on the basis of race, age, color, gender or national origin and shall be subject to the same rules as other organizations that contract with public bodies to account for the use of the funds provided; however, if the faith-based organization segregates public funds into separate accounts, only the accounts and programs funded with public funds shall be subject to audit by the public body. *(Code of Virginia,* § 2.2-4343.1 E).

In every contract over $10,000, the provisions in Sections 10.2.1 and 10.2.2. below apply:

10.2.1 During the performance of this contract, the MCO agrees as follows:

A. The MCO will not discriminate against any employee or applicant for employment because of race, religion, color, sex, national origin, age, disability, or any other basis prohibited by state law relating to discrimination in employment, except where there is a bona fide occupational qualification reasonably necessary to the normal operation of the MCO. The MCO agrees to post in conspicuous places, available to employees and applicants for employment, notices setting forth the provisions of this nondiscrimination clause.

B. The MCO, in all solicitations or advertisements for employees placed by or on behalf of the MCO, will state that such MCO is an equal opportunity employer.

C. Notices, advertisements and solicitations placed in accordance with federal law, rule or regulation shall be deemed sufficient for the purpose of meeting these requirements.

10.2.2 The MCO will include the provisions of 9.2.1 above in every subcontract or purchase order over $10,000, so that the provisions will be binding upon each subcontractor or vendor.

10.3 Ethics in Public Contracting

By submitting their applications, MCO's certify that their applications are made without collusion or fraud and that they have not offered or received any kickbacks or inducements from any other MCO, supplier, manufacturer or subcontractor in connection with their application, and that they have not conferred on any public employee having official responsibility for this procurement transaction any

payment, loan, subscription, advance, deposit of money, services or anything of more than nominal value, present or promised, unless consideration of substantially equal or greater value was exchanged.

10.4 Immigration Reform and Control Act Of 1986

By submitting their applications, MCO's certify that they do not and will not during the performance of this contract employ illegal alien workers or otherwise violate the provisions of the federal Immigration Reform and Control Act of 1986.

10.5 Debarment Status

By submitting their applications, MCO's certify that they are not currently debarred by the Commonwealth of Virginia or any other federal, state or local government from submitting bids or applications on any type of contract, nor are they an agent of any person or entity that is currently so debarred.

10.6 Antitrust

By entering into a contract, the MCO conveys, sells, assigns, and transfers to the Commonwealth of Virginia all rights, title and interest in and to all causes of action it may now have or hereafter acquire under the antitrust laws of the United States and the Commonwealth of Virginia, relating to the particular goods or services purchased or acquired by the Commonwealth of Virginia under said contract.

10.7 Mandatory Use of State Form and Terms and Conditions

Failure to submit an application on the official state form, in this case the completed and signed Contract Cover Sheet, shall be a cause for rejection of the application. Modification of or additions to the General Terms and Conditions of the solicitation may be cause for rejection of the application; however, the Commonwealth reserves the right to decide, on a case by case basis, in its sole discretion, whether to reject such a application.

10.8 Clarification of Terms

If any prospective MCO has questions about the specifications or other solicitation documents, the prospective MCO should contact Ms. Suzanne Gore via instructions indicated in Section 8 of this contract. Any revisions to the solicitation will be made only by addendum issued by the buyer.

10.9 Payment

1. To Prime MCO:

   A. Invoices for items ordered, delivered and accepted shall be submitted by the MCO directly to the payment address shown on the purchase order/contract. All invoices shall show the state contract number and/or purchase order number; social security number (for individual contractors) or the federal employer identification number (for proprietorships, partnerships, and corporations).

   B. Any payment terms requiring payment in less than 30 days will be regarded as requiring payment 30 days after invoice or delivery, whichever occurs last. This shall not affect offers of discounts for payment in less than 30 days, however.

   C. All goods or services provided under this contract or purchase order, that are to be paid for with

public funds, shall be billed by the MCO at the contract price, regardless of which public agency is being billed.

D. The following shall be deemed to be the date of payment: the date of postmark in all cases where payment is made by mail, or the date of offset when offset proceedings have been instituted as authorized under the Virginia Debt Collection Act.

E. Unreasonable Charges: Under certain emergency procurements and for most time and material purchases, final job costs cannot be accurately determined at the time orders are placed. In such cases, Contractors should be put on notice that final payment in full is contingent on a determination of reasonableness with respect to all invoiced charges. Charges that appear to be unreasonable will be researched and challenged, and that portion of the invoice held in abeyance until a settlement can be reached. Upon determining that invoiced charges are not reasonable, the Commonwealth shall promptly notify the MCO, in writing, as to those charges which it considers unreasonable and the basis for the determination. A MCO may not institute legal action unless a settlement cannot be reached within thirty (30) days of notification. The provisions of this section do not relieve an agency of its prompt payment obligations with respect to those charges that are not in dispute *(Code of Virginia,* § 2.2-4363).

2. To Subcontractors:

A. A MCO awarded a contract under this solicitation is hereby obligated:

a. To pay the subcontractor(s) within seven (7) days of the MCO's receipt of payment from the Commonwealth for the proportionate share of the payment received for work performed by the subcontractor(s) under the contract; or
b. To notify the agency and the subcontractor(s), in writing, of the MCO's intention to withhold payment and the reason.

B. The MCO is obligated to pay the subcontractor(s) interest at the rate of one percent per month (unless otherwise provided under the terms of the contract) on all amounts owed by the MCO that remain unpaid seven (7) days following receipt of payment from the Commonwealth, except for amounts withheld as stated in (2) above. The date of mailing of any payment by U. S. Mail is deemed to be payment to the addressee. These provisions apply to each sub-tier MCO performing under the primary contract. A MCO's obligation to pay an interest charge to a subcontractor may not be construed to be an obligation of the Commonwealth.

3. Each prime MCO who wins an award in which provision of a SWAM procurement plan is a condition to the award, shall deliver to the contracting agency or institution, on or before request for final payment, evidence and certification of compliance (subject only to insubstantial shortfalls and to shortfalls arising from subcontractor default) with the SWAM procurement plan. Final payment under the contract in question may be withheld until such certification is delivered and, if necessary, confirmed by the agency or institution, or other appropriate penalties may be assessed in lieu of withholding such payment.

10.10 Precedence of Terms

The following General Terms and Conditions: APPLICABLE LAWS AND COURTS, ANTI-DISCRIMINATION, ETHICS IN PUBLIC CONTRACTING, IMMIGRATION REFORM AND CONTROL ACT OF 1986, DEBARMENT STATUS, ANTITRUST, MANDATORY USE OF STATE FORM AND TERMS AND CONDITIONS, CLARIFICATION OF TERMS, PAYMENT shall apply in

all instances. In the event there is a conflict between any of the other General Terms and Conditions and any Special Terms and Conditions in this solicitation, the Special Terms and Conditions shall apply.

10.11 Qualifications of MCO's

The Commonwealth may make such reasonable investigations as deemed proper and necessary to determine the ability of the MCO to perform the services/furnish the goods and the MCO shall furnish to the Commonwealth all such information and data for this purpose as may be requested. The Commonwealth reserves the right to inspect MCO's physical facilities prior to award to satisfy questions regarding the MCO's capabilities. The Commonwealth further reserves the right to reject any application if the evidence submitted by, or investigations of, such MCO fails to satisfy the Commonwealth that such MCO is properly qualified to carry out the obligations of the contract and to provide the services and/or furnish the goods contemplated therein.

10.12 Testing And Inspection

The Commonwealth reserves the right to conduct any test/inspection it may deem advisable to ensure goods and services conform to the specifications.

10.13 Assignment of Contract

A contract shall not be assignable by the MCO in whole or in part without the written consent of the Commonwealth. Any assignment made in violation of this section will be void.

10.14 Changes To The Contract

Changes can be made to the contract in any of the following ways:

1. The parties may agree in writing to modify the scope of the contract. An increase or decrease in the price of the contract resulting from such modification shall be agreed to by the parties as a part of their written contract to modify the scope of the contract.

2. The Department may order changes within the general scope of the contract at any time by written notice to the MCO. Changes within the scope of the contract include, but are not limited to, things such as services to be performed or changes in programs, policies, legislation or operations. The MCO shall comply with the notice upon receipt. The MCO shall be compensated for any additional costs incurred as the result of such order and shall give the Department a credit for any savings. Said compensation shall be determined by one of the following methods:

    A. By mutual contract between the parties in writing; or

    B. By agreeing upon a unit price or using a unit price set forth in the contract, if the work to be done can be expressed in units, and the MCO accounts for the number of units of work performed, subject to the Department's right to audit the MCO's records and/or to determine the correct number of units independently; or

    C. By ordering the MCO to proceed with the work and keep a record of all costs incurred and savings realized. A markup for overhead and profit may be allowed if provided by the contract. The same markup shall be used for determining a decrease in price as the result of savings realized. The MCO shall present the Department with all vouchers and records of expenses incurred and savings realized. The Department shall have the right to audit the records of the MCO as it deems necessary to determine costs or savings.

Any claim for an adjustment in price under this provision must be asserted by written notice to the Department within thirty (30) days from the date of receipt of the written order from the Department. If the parties fail to agree on an amount of adjustment, the question of an increase or decrease in the contract price or time for performance shall be resolved in accordance with the procedures for resolving disputes provided by the Disputes Clause of this contract. Neither the existence of a claim nor a dispute resolution process, litigation or any other provision of this contract shall excuse the MCO from promptly complying with the changes ordered by the Department or with the performance of the contract generally.

10.15 Default

In case of failure to deliver goods or services in accordance with the contract terms and conditions, the Commonwealth, after due oral or written notice, may procure them from other sources and hold the MCO responsible for any resulting additional purchase and administrative costs. This remedy shall be in addition to any other remedies, which the Commonwealth may have.

10.16 Insurance

By signing and submitting a bid or application under this solicitation, the MCO certifies that if awarded the contract, it will have the following insurance coverage at the time the contract is awarded. For construction contracts, if any subcontractors are involved, the subcontractor will have workers' compensation insurance in accordance with §§ 2.2-4332 and 65.2-800 et seq. of the *Code of Virginia*. The MCO further certifies that the MCO and any subcontractors will maintain these insurance coverage during the entire term of the contract and that all insurance coverage will be provided by insurance companies authorized to sell insurance in Virginia by the Virginia State Corporation Commission.

MINIMUM INSURANCE COVERAGES AND LIMITS REQUIRED FOR MOST CONTRACTS:

1. Professional Liability Insurance for the MCO's Medical Director: Insurance in the amount of at least one million dollars ($1,000,000) for each occurrence shall be maintained by the MCO for the Medical Director.

2. Workers' Compensation: Statutory requirements and benefits: Coverage is compulsory for employers of three or more employees, to include the employer. Contractors who fail to notify the Commonwealth of increases in the number of employees that change their workers' compensation requirements under the *Code of Virginia* during the course of the contract shall be in noncompliance with the contract. In the event any work is subcontracted, the MCO shall require its subcontractor(s) similarly to provide workers' compensation insurance for all the latter's employees working in the Commonwealth. Any subcontract executed with a firm not having the requisite workers' compensation coverage will be considered void by the Commonwealth of Virginia.

3. Employer's Liability: $100,000.

4. Commercial General Liability: $1,000,000 per occurrence. Commercial General Liability is to include bodily injury and property damage, personal injury and advertising injury, products and completed operations coverage. The Commonwealth of Virginia must be named as an additional insured and so endorsed on the policy.

5. Automobile Liability: $1,000,000 per occurrence. (Only used if motor vehicle is to be used in

the contract.)

10.17 Drug-Free Workplace

During the performance of this contract, the MCO agrees to:

1. Provide a drug-free workplace for the MCO's employees;

2. Post in conspicuous places, available to employees and applicants for employment, a statement notifying employees that the unlawful manufacture, sale, distribution, dispensation, possession, or use of a controlled substance or marijuana is prohibited in the MCO's workplace and specifying the actions that will be taken against employees for violations of such prohibition;

3. State in all solicitations or advertisements for employees placed by or on behalf of the MCO that the MCO maintains a drug-free workplace; and

4. Include the provisions of the foregoing clauses in every subcontract or purchase order of over $10,000, so that the provisions will be binding upon each subcontractor or vendor.

For the purposes of this section, *"drug-free workplace"* means a site for the performance of work done in connection with a specific contract awarded to a MCO, the employees of whom are prohibited from engaging in the unlawful manufacture, sale, distribution, dispensation, possession or use of any controlled substance or marijuana during the performance of the contract.

10.18 Nondiscrimination of Contractors

A Bidder, MCO, or MCO shall not be discriminated against in the solicitation or award of this contract because of race, religion, color, sex, national origin, age, disability, faith-based organizational status, any other basis prohibited by state law relating to discrimination in employment or because the bidder or MCO employs ex-offenders unless the state agency, department or institution has made a written determination that employing ex-offenders on the specific contract is not in its best interest. If the award of this contract is made to a faith-based organization and an individual, who applies for or receives goods, services, or disbursements provided pursuant to this contract objects to the religious character of the faith-based organization from which the individual receives or would receive the goods, services, or disbursements, the public body shall offer the individual, within a reasonable period of time after the date of his objection, access to equivalent goods, services, or disbursements from an alternative provider.

11. SPECIAL TERMS AND CONDITIONS

11.1 Access to Premises

The MCO shall allow duly authorized agents or representatives of the State or Federal Government, during normal business hours, access to MCO's and subcontractors' premises, to inspect, audit, monitor or otherwise evaluate the performance of the MCO's and subcontractor's contractual activities and shall forthwith produce all records requested as part of such review or audit. In the event right of access is requested under this section, the MCO and subcontractor shall, upon request, provide and make available staff to assist in the audit or inspection effort, and provide adequate space on the premises to reasonably accommodate the State or Federal personnel conducting the audit or inspection effort. All inspections or audits shall be conducted in a manner as will not unduly interfere with the performance of MCO or subcontractor's activities. The MCO will be given thirty (30) calendar days to respond to any preliminary findings of an audit before the Department shall finalize its findings. All information so obtained will be accorded confidential treatment as provided under applicable law.

The Department, the Office of the Attorney General of the Commonwealth of Virginia, the federal Department of Health and Human Services, and/or their duly authorized representatives shall be allowed access to evaluate through inspection or other means, the quality, appropriateness, and timeliness of services performed under this contract.

11.2 Access to and Retention of Records

In addition to the requirements outlined below, the MCO must comply, and must require compliance by its subcontractors with the security and confidentiality of records standards.

11.2.1 Access to records

a. The Department, its duly authorized representatives and State and Federal auditors shall have access to any books, fee schedules, documents, papers, and records of the MCO and any of its subcontractors.

b. The Department, or its duly authorized representatives, shall be allowed to inspect, copy, and audit any of the above documents, including, medical and/or financial records of the MCO and its subcontractors.

11.2.2 Retention of records

The MCO shall retain all records and reports relating to this contract for a period of six (6) years after final payment is made under this contract or in the event that this contract is renewed six (6) years after the renewal date. When an audit, litigation, or other action involving records is initiated prior to the end of said period, however, records shall be maintained for a period of six (6) years following resolution of such action or longer if such action is still ongoing. Copies on microfilm or other appropriate media of the documents contemplated herein may be substituted for the originals provided that the microfilming or other duplicating procedures are reliable and are supported by an effective retrieval system which meets legal requirements to support litigation, and to be admissible into evidence in any court of law.

11.3 Advertising

In the event a contract is awarded for services resulting from this application, no indication of such sales or services to DMAS will be used in product literature or advertising without prior written permission from DMAS. The MCO shall not state in any of its advertising or product literature that the Commonwealth of Virginia or any agency or institution of the Commonwealth has purchased or uses its products or services without prior written permission from DMAS. DMAS must approve any advertising, marketing or press release connected with this contract.

11.4 Audit

The MCO shall retain all books, records, and other documents relative to this contract for six (6) years after final payment, or longer if audited by the Commonwealth of Virginia, whichever is sooner. The agency, its authorized agents, and/or state auditors shall have full access to and the right to examine any of said materials during said period.

11.5 Availability of Funds

It is understood and agreed between the parties herein that the agency shall be bound hereunder only to the extent of the funds available or which may hereafter become available for the purpose of this contract.

11.6 Award

The Application award will be made based upon the potential VALTC MCOs deemed to be fully qualified and best suited among those submitting application requests on the basis of the evaluation factors included in the requirements for application award. The award document will be a contract incorporating by reference all the requirements, terms and conditions of this solicitation.

The Commonwealth may cancel this Request for Applications or reject applications at any time prior to an award, and is not required to furnish a statement of the reasons why a particular application was not deemed to be the most advantageous *(Code of Virginia,* § 2.2-4359D).

11.7 Cancellation of Contract

The Department reserves the right to cancel and terminate any resulting contract, in part or in whole, without penalty, upon 180 days written notice to the MCO. Any contract cancellation notice shall not relieve the MCO of the obligation to deliver and/or perform on all outstanding services issued prior to the effective date of cancellation.

11.7.1 Termination

This Contract may be terminated in whole or in part:

a. By the Department or the MCO, for convenience, with not less than 180 days prior written notice, which notice shall specify the effective date of the termination,

b. By the Department, in whole or in part, if funding from Federal, State, or other sources is withdrawn, reduced, or limited;

c. By the Department if the Department determines that the instability of the MCO's financial condition threatens delivery of services and continued performance of the MCO's responsibilities; or

d. By the Department if the Department determines that the MCO has failed to satisfactorily perform its contracted duties and responsibilities.

Each of these conditions for contract termination is described in the following paragraphs.

11.7.2 Termination for convenience

The MCO may terminate this contract with or without cause, upon 180 days written notice to the Department. In addition, the MCO may terminate the contract by opting out of the renewal clause.

11.7.3 Termination for unavailable funds

The MCO understands and agrees that the Department shall be bound only to the extent of the funds available or which may become available for the purpose of this resulting contract. When the Department makes a written determination that funds are not adequately appropriated or otherwise unavailable to support continuance of performance of this contract, the Department shall, in whole or in part, cancel or terminate this contract.

The Department's payment of funds for purposes of this contract is subject to and conditioned upon the availability of funds for such purposes, whether Federal and/or State funds. The Department may terminate this contract upon written notice to the MCO at any time prior to the completion of this contract, if, in the sole opinion of the Department, funding becomes unavailable for these services or such funds are restricted or reduced. In the event that funds are restricted or reduced, it is agreed by both parties that, at the sole discretion of the Department, this contract may be amended. If the MCO shall be unable or unwilling to provide covered services at reduced rates, the contract shall be terminated.

No damages, losses, or expenses may be sought by the MCO against the Department, if, in the sole determination of the Department, funds become unavailable before or after this contract between the parties is executed. A determination by the Department that funds are not appropriated or are otherwise inadequate or unavailable to support the continuance of this contract shall be final and conclusive.

11.7.4 Termination because of financial instability

In the event the MCO becomes financially unstable to the point of threatening the ability of the Department to obtain the services provided for under the contract, ceases to conduct business in the normal course, makes a general assignment for the benefit of creditors, or suffers or permits the appointment of a receiver for its business or assets, the Department may, at its option, immediately terminate this contract effective at the close of business on a date specified by the Department. In the event the Department elects to terminate the contract under this provision, the MCO shall be notified in writing, by either certified or registered mail, specifying the date of termination. The MCO shall submit a written waiver of the licensee's rights under the Federal bankruptcy laws.
In the event of the filing of a petition in bankruptcy by a principal network provider or subcontractor, the MCO shall immediately so advise the Department. The MCO shall ensure that all tasks that have been delegated to its subcontractor(s) are performed in accordance with the terms of this contract.

11.7.5 Termination for default

The Department may terminate the contract, in whole or in part, if the Department determines that the MCO has failed to satisfactorily perform its duties and responsibilities under this contract and is unable to cure such failure within a reasonable period of time as specified in writing by the Department, taking into

consideration the gravity and nature of the default. Such termination shall be referred to herein as "Termination for Default."

a. Upon determination by the Department that the MCO has failed to satisfactorily perform its duties and responsibilities under this contract, the MCO shall be notified in writing, by either certified or registered mail, of the failure and of the time period which has been established to cure such failure. If the MCO is unable to cure the failure within the specified time period, the Department can notify the MCO in writing within thirty (30) calendar days of the last day of the specified time period that the agreement, has been terminated in full or in part, for default. This written notice will identify all of the MCO's responsibilities in the case of the termination, including responsibilities related to enrollee notification, network provider notification, refunds of advance payments, return or destruction of Department data and liability for medical claims.

b. In the event that DMAS determines that the MCO's failure to perform its duties and responsibilities under this contract results in a substantial risk to the health and safety of Medicaid enrollees, DMAS may terminate this contract immediately without notice.

c. If, after notice of termination for default, it is determined by the Department or by a court of law that the MCO was not in default or that the MCO's failure to perform or make progress in performance was due to causes beyond the control of and without error or negligence on the part of the MCO or any of its subcontractors, the notice of termination shall be deemed to have been issued as a termination for the convenience of the Department, and the rights and obligations of the parties shall be governed accordingly.

d. In the event of termination for default, in full or in part, as provided for under this clause, the Department may procure or contract from other sources, upon such terms and in such manner as is deemed appropriate by the Department, supplies or services similar to those terminated, and the MCO shall be liable for any costs for such similar supplies and services and all other damages allowed by law. In addition, the MCO shall be liable to the Department for administrative costs incurred to procure such similar supplies or services as are needed to continue operations. In the event of a termination for default prior to the start of operations, any claim the MCO may assert shall be governed by the procedures defined by the Department for handling contract termination. Nothing herein shall be construed as limiting any other remedies that may be available to the Department.

e. In the event of a termination for default during ongoing operations, the MCO shall be paid for any outstanding payments due less any assessed damages.

11.8 Termination Procedures

11.81 Liability for medical claims

The MCO shall be liable for all medical and long-term care claims incurred up to the date of termination. This shall include all of the hospital inpatient claims incurred for enrollees hospitalized at the time of termination.

11.8.2 Refunds of advanced payments

If the contract is terminated under this section, the MCO shall be entitled to be paid a pro-rated capitation amount for the month in which notice of termination was effective to cover the services rendered to enrollees prior to the termination. The MCO shall not be entitled to be paid for any services performed after the effective date of the termination. The MCO shall, within thirty (30) calendar days of receipt,

return any funds advanced for coverage of members for periods after the date of termination of the contract.

11.8.3 Notification of enrollees

In all cases of termination, the MCO shall be responsible for notifying enrollees about the termination, and the Department shall be responsible for reassigning enrollees to new MCOs, as appropriate. In cases of termination for default or financial instability, the MCO shall be responsible for covering the costs associated with such notification. In cases of termination for convenience, the costs associated with such notification shall be the responsibility of the party which terminated the contract. In cases of termination due to unavailability of funds or termination in the best interest of the Department, the Department shall be responsible for the costs associated with such notification. The MCO shall conduct these notification activities within a time frame established by the Department.

11.8.4 Notification of network providers

In all cases of termination, the MCO shall be responsible for notifying its network providers about the termination of the VALTC Contract and about the reassigning of its enrollees to other MCOs and for covering the costs associated with such notification. The MCO shall conduct these notification activities within a time frame established by the Department.

11.8.5 Other procedures on termination

Upon delivery by certified or registered mail to the MCO of a Notice of Termination specifying the nature of the termination and the date upon which such termination becomes effective, the MCO shall:

a. Stop work under the contract on the date specified and to the extent specified in the Notice of Termination;

b. Place no further orders or subcontracts for materials, services, or facilities;

c. Terminate all orders, provider network contracts and subcontracts to the extent that they relate to the performance of work terminated by the Notice of Termination;

d. Assign to the Department in the manner and to the extent directed all of the rights, titles, and interests of the MCO under the orders or subcontracts so terminated, in which case the Department shall have the right, at its discretion, to settle or pay any or all claims arising out of the termination of such orders and subcontracts;

e. Within ten (10) business days from the effective date of termination, transfer title to the State (to the extent that the title has not already been transferred) and deliver, in the manner and to the extent directed, all data, other information, and documentation in any form that relates to the work terminated by the Notice of Termination;

f. Complete the performance of such part of the work as has not been specified for termination by the Notice of Termination;

g. Take such action as may be necessary, or as the Department may direct, for the protection and preservation of the property which is in the possession of the MCO and in which the Department has acquired or may acquire interest; and,

h. Assist the Department in taking the steps necessary to assure an orderly transition of requested services after notice of termination.

The MCO hereby acknowledges that any failure or unreasonable delay on its part in affecting a smooth transition will cause irreparable injury to the State which may not be adequately compensable in damages. The MCO agrees that the Department may, in such event, seek and obtain injunctive relief as well as monetary damages. Any payments made by the Department pursuant to this section may also constitute an element of damages in any action in which MCO fault is alleged.

The MCO shall proceed immediately with the performance of the above obligations, notwithstanding any delay in determining or adjusting the amount of any item of reimbursable price under this clause.

Upon termination of this contract in full, the Department shall require the MCO to return to the Department any property made available for its use during the contract term.

11.9 Payment

The MCO shall be prepared to provide the full range of services requested under this contract, on site and operationally ready to begin work by the implementation date established by DMAS. DMAS will provide adequate prior notice of at least 120 days of the implementation date. Upon approval of the MCO's operational readiness and a determined start date, DMAS shall make payments as described in Section 6.

11.10 Identification of Application Envelope

The signed application should be returned in a separate envelope or package sealed and identified as follows:

The signed application should be returned in a separate envelope or package sealed and identified as follows:

From:_____ _____

Name of MCO Due Date /Time

_____ _____

Street or Box Number City, State, Zip Code

Name of Contract/Purchase Officer:

The envelope should be addressed as directed on Page 1 of the solicitation.

If an application not contained in the special envelope is mailed, the MCO takes the risk that the envelope, even if marked as described above, may be inadvertently opened and the information compromised which may cause the application to be disqualified. Applications may be hand delivered to the designated location in the office issuing the solicitation. No other correspondence or other applications should be placed in the envelope.

11.11 Indemnification

The MCO agrees to indemnify, defend and hold harmless the Commonwealth of Virginia, its officers, agents, and employees from any claims, damages and actions of any kind or nature, whether at law or in

equity, arising from or caused by the use of any materials, goods, or equipment of any kind or nature furnished by the MCO/any services of any kind or nature furnished by the MCO, provided that such liability is not attributable to the sole negligence of the using agency or to failure of the using agency to use the materials, goods, or equipment in the manner already and permanently described by the MCO on the materials, goods or equipment delivered.

11.12 SWAM Businesses Subcontracting and Evidence of Compliance

Each prime contractor who wins an award in which provision of a small, women or minority-owned (SWAM) procurement plan is a condition of the award, shall deliver to the contracting agency or institution evidence and certification of compliance (subject only to insubstantial shortfalls and to shortfalls arising from subcontractor default) with the SWAM procurement plan. When such business has been subcontracted to these firms and quarterly during the contract period, the MCO agrees to furnish the purchasing office the following information: name of firm, phone number, total dollar amount subcontracted ,category type (small, women, or minority-owned), and type of product/service provided on a quarterly basis. Final payment under the contract in question may be withheld until such certification is delivered and, if necessary, confirmed by the agency or institution, or other appropriate remedies may be assessed in lieu of withholding such payment. Names of SWAM certified firms may be available from the Department of Minority Business Enterprise at www.dmbe.virginia.gov.

11.13 Prime MCO Responsibilities

The MCO shall be responsible for completely supervising and directing the work under this contract and all subcontractors that it may utilize, using its best skill and attention. Subcontractors who perform work under this contract shall be responsible to the prime MCO. The MCO agrees that it is as fully responsible for the acts and omissions of its subcontractors and of persons employed by it as it is for the acts and omissions of its own employees.

11.14 Renewal of Contract

This contract may be renewed by the Commonwealth upon written contract of both parties for three successive one-year periods, under the terms of the current contract, and at a reasonable time (approximately 90 days) prior to the expiration.

The contract shall automatically renew for six additional months if, on the ending date of this contract, the MCO and the Department are actively involved in good faith renegotiations of this contract or negotiation of another risk based contract. The capitation rates for this automatic renewal period will be set at the discretion of the Department.

The MCO may opt out of the above automatic renewal clause. In order to do so, the MCO must notify the Department in writing at least six (6) full calendar months prior to the renewal. If the MCO fails to notify the Department of non-renewal on or before this date, the contract will be automatically renewed.

11.15 Confidentiality of Information

By submitting an application, the MCO agrees that information or data obtained by the MCO from DMAS during the course of determining and/or preparing a response to this contract may not be used for any other purpose than determining and/or preparing the MCO's response. Such information or data may not be disseminated or discussed for any reasons not directly related to the determination or preparation of the MCO's response to this contract.

Except as otherwise required by law, including, but not limited to, the Virginia Freedom of Information Act, access to confidential information shall be limited by the MCO and the Department to persons who or agencies which require the information in order to perform their duties related to this contract, including the United States Department of Health and Human Services; the Office of the Attorney General of the Commonwealth of Virginia, including the Medicaid Fraud Control Unit; and such others as may be required by the Department.

In complying with the requirements of this section, the MCO and the Commonwealth shall follow the requirements of 42 CFR Part 431, Subpart F, as amended, regarding confidentiality of information concerning applicants and recipients of public assistance, and 42 CFR Part 2, as amended, regarding confidentiality of alcohol and drug abuse patient records.

The MCO must have written policies and procedures for maintaining the confidentiality of data, including medical records and enrollee information and appointment records for treatment of sexually transmitted diseases and submit prior to signing the initial contract, upon revision or on request to the Department. The MCO shall comply with the Department's Security Requirements for Vendors.

11.16 HIPAA Compliance

The MCO shall comply, and shall ensure that any and all subcontractors comply, with all State and Federal laws and Regulations with regards to handling, processing, or using Health Care Data. This includes but is not limited to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations as it pertains to this contract, and the MCO shall keep abreast of the regulations. Since this is a federal law and the regulations apply to all health care information, the MCO shall comply with the HIPAA regulations at no additional cost to DMAS. The MCO will also be required to enter into a DMAS-supplied HIPAA Business Associate Contract with DMAS to comply with the regulations protecting Health Care Data. A template of this Contract is available on the DMAS Internet Site at http://www.DMAS.virginia.gov/hpa-home.htm

The use or disclosure of information concerning services or enrollees obtained in connection with the performance of this contract shall be in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Final Rule requirements and the State Plan and is restricted to purposes directly related to the administration and the provision of services provided under this contract.

11.16.1 Disclosure and confidentiality

The MCO must have a confidentiality contract in place with individuals of its workforce who have access to PHI. Issuing and maintaining these confidentiality contracts will be the responsibility of the MCO. The Department shall have the option to inspect the maintenance of said confidentiality contracts.

11.16.2 Disclosure to workforce

The MCO shall not disclose PHI to any member of its workforce except to those persons who have authorized access to the information, who have received privacy training in PHI, and who have signed a contract to hold the information in confidence.

The MCO understands and agrees that data, materials, and information disclosed to the MCO may contain confidential and protected data. The MCO, therefore, must ensure that data, material, and information gathered, based upon or disclosed to the MCO for the purpose of this contract, shall not be disclosed to others or discussed with other outside parties without the prior written consent of the Commonwealth of Virginia.

11.16.3 Safeguards

The MCO shall implement and maintain appropriate safeguards to prevent the use and disclosure of protected health information (PHI), other than as provided in this contract. A description of such safeguards must be in the form of a contractor Data Security Plan (DSP). Upon reasonable request, the MCO shall give the Department access for inspection and copying to the MCO's facilities used for the maintenance or processing of PHI, and to books, records, practices, policies and procedures concerning the use and disclosure of PHI, including DSPs, for the purpose of determining the MCO's compliance with this contract.

11.16.4 Accounting of disclosures

The MCO shall maintain an ongoing log of the details relating to any disclosures of PHI it makes (including, but not limited to, the date made, the name of the person or organization receiving the PHI, the recipient's address, if known, a description of the PHI disclosed, and the reason for the disclosure), as required by 45 CFR, Section 164.528. The MCO shall, within thirty (30) days of the Department's request, make such log available to the Department as needed, for the Department to provide a proper accounting of disclosures to its patients.

11.16.5 Disclosure to the U.S. Department of Health and Human Services

The MCO shall make its internal practices, books, and records relating to the use and disclosure of PHI received from the Department (or created or received by the MCO on behalf of the Department) available to the Secretary of the Department of Health and Human Services (DHHS) or its designee for purposes of determining the MCO's compliance with HIPAA and with the Privacy Regulations issued pursuant thereto. The Department shall provide the MCO with copies of any information it has made available to DHHS under this section of this contract.

11.16.6 Reporting

The MCO shall report to the Department within thirty (30) days of discovery, any use or disclosure of PHI made in violation of this contract or any law. The MCO shall implement and maintain sanctions for any employee, subcontractor, or agent who violates the requirements in this contract or the HIPAA privacy regulations. The MCO shall, as requested by the Department, take steps to mitigate any harmful effect of any such violation of this contract.

11.16.7 Access to PHI

The MCO shall make an individual's PHI available to the Department within thirty (30) days of an individual's request for such information as notified and in the format requested by the Department.

11.16.8 Amendment to PHI

The MCO shall make PHI available for amendment and correction and shall incorporate any amendments or corrections to PHI within thirty (30) days of notification by the Department.

The MCO hereby agrees to comply with the terms set forth in the Department's Confidentiality Contract, Appendix M.

11.16.9 Data security plan

By executing this contract, the MCO agrees to work with the Department's Division of Internal Audit to create a Data Security Plan governing the MCO's use of Department data. Appendix N summarizes the basic requirements for such a Data Security Plan, the final contents of which will be negotiated between the MCO and the Division of Internal Audit.

11.16.10 Audits, inspections and enforcement

With reasonable notice, the Department may inspect the facilities, systems, books and records of the MCO to monitor compliance with HIPAA. The MCO shall promptly remedy any violation of any term of HIPAA and shall certify the same to the Department in writing. The fact the Department inspects, or fails to inspect, or has the right to inspect, the MCO's facilities, systems and procedures does not relieve the MCO of its responsibility to comply with HIPAA, nor does the Department's failure to detect, or to detect but fail to call the MCO's attention to or require remediation of any unsatisfactory practice constitute acceptance of such practice or waiving of the Department's enforcement rights.

The Department may terminate the Contract without penalty if the MCO repeatedly violates HIPAA or any provision hereof, irrespective of whether, or how promptly, the MCO may remedy such violation after being notified of the same. In case of any such termination, the Department shall not be liable for the payment of any services performed by the MCO after the effective date of the termination, and the Department shall be liable to the MCO in accordance with the Contract for services provided prior to the effective date of termination.

The MCO acknowledges and agrees that any individual who is the subject of PHI disclosed by the Department to the MCO is a third party beneficiary of HIPAA and may, to the extent otherwise permitted by law, enforce directly against the MCO any rights such individual may have under this HIPAA, the Contract, or any other law relating to or arising out of the MCO's violation of any provision of HIPAA.

11.17 Obligation of MCO

By submitting an application, the MCO covenants and agrees that it has satisfied itself of the conditions to be met, and fully understands its obligations, and that it will have no right to cancel its application or to relief of any other nature because of its misunderstanding or lack of information.

11.18 Independent MCO

Any MCO awarded a contract will be considered an independent MCO, and neither the MCO, nor personnel employed by the MCO, is to be considered an employee or agent of DMAS.

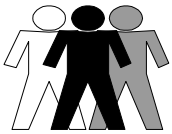
11.19 Ownership of Intellectual Property

All copyright and patent rights to all papers, reports, forms, materials, creations, or inventions created or developed in the performance specific to this contract shall become the sole property of the Commonwealth. DMAS shall have open access to the above. On request, the MCO shall promptly provide an acknowledgement or assignment in a tangible form satisfactory to the Commonwealth to evidence the Commonwealth's sole ownership of specifically identified intellectual property created or developed in the performance of the contract.

11.20 Subsidiary-Parent Relationship

In the event the MCO is a subsidiary or division of a parent organization, the MCO must include in the application, a signed statement by the chief executive officer of the parent organization pledging the full resources of the parent organization to meet the responsibilities of the subsidiary organization under contract to the Department. DMAS must be notified within 10 days of any change in ownership as wall as a letter explaining how the changes affect the MCO's relationship with the Department. Any change in ownership will not relieve the original parent of its obligation of pledging its full resources to meet the obligations of the contract with DMAS without the expressed written consent of the DMAS Director.

APPENDIX A Enrollment Flow Charts



Waiver recipient

New to EDCD Waiver and Medicaid

1. Screening Team (ST) completes UAI, determines eligibility for NF level of care (LOC), offers choice of institution, PACE, or wavier services, and provides MCO comparison chart and VALTC information sheet. Potential participant may call Enrollment Broker (EB) for info on plan choice. ST sends screening package to VALTC transition coordinator (TC) and 1st Health.

If choice is EDCD

Yes

3. VALTC Transition Coordinator (TC) enters EDCD benefit plan indicator in VAMMIS. VALTC TC sends daily report of new eligibles and 1st page of UAI to enrollment broker by secure email. Participant covered for acute care under FFS.

4. EB conducts outbound calls (up to 2) to determine plan choice and makes MCO enrollment into VAMMIS. EB enters participant MCO selection in VAMMIS. If participant does not select plan within 3 days of call, participant will be automatically enrolled in an MCO. MCO enrollment date is a system generated date in the future (within 6-10 calendar days).

2. Participant applies to DSS for financial eligibility:
$$ Eligible for LTC services?
If yes, DSS enters participant in VAMMIS.
DSS sends DMAS 122 to VALTC (initially, annually, and as needed) to indicate PMA amount.

5. 1) EB sends an enrollment report to VALTC TC confirm MCO selection.
2) If participant wishes to change plans (within the first 90 days), EB enters the change in plans effective next monthly cycle.

6. FRIDAY (Close of Business): MCO receives weekly file transfer (834) of new VALTC EDCD participants and transition reports (including patient pay amount).

7. WEDNESDAY: MCO responsible for participant.

8. MCO sends ID card, member handbook, provider directory within 5 business days of receipt of enrollment file.

9. MCO does face to face screening and assessment (signed by an RN) and develops service plan.

10. MCO authorizes waiver services in their system.

11. LTC services start within 30 days (per regulation) of waiver enrollment into VAMMIS.

Waiver recipient

"Initial Migration:"
Existing Fee-for-Service EDCD waiver enrollees

November: DMAS sends VALTC information letter to participants advising of program changes.

December 18: VALTC system run picks up existing FFS waiver recipients in affected FIPS for 2/1 enrollment effective date.

Pre-Assignment:

Based on network comparison with most recent provider and Phase I participation history. VALTC MCO pre-assignment cycle including letter & comp chart urging participants to call Enrollment Broker.

January 18: VALTC system run picks up existing FFS waiver recipients in affected FIPS for 3/1 enrollment effective date.

Pre-Assignment:

Based on network comparison with most recent provider and Phase I participation history. VALTC MCO pre-assignment cycle including letter & comp chart urging participants to call Enrollment Broker.

Participant informs EB of MCO selection or maintains preassigned MCO.

On 1/18 & 2/18 (depending on month of preassignment) DMAS sends to VALTC MCO 834, transition report, pre-authorized services, and PMA amount.

MCO sends ID card, member handbook, provider directory

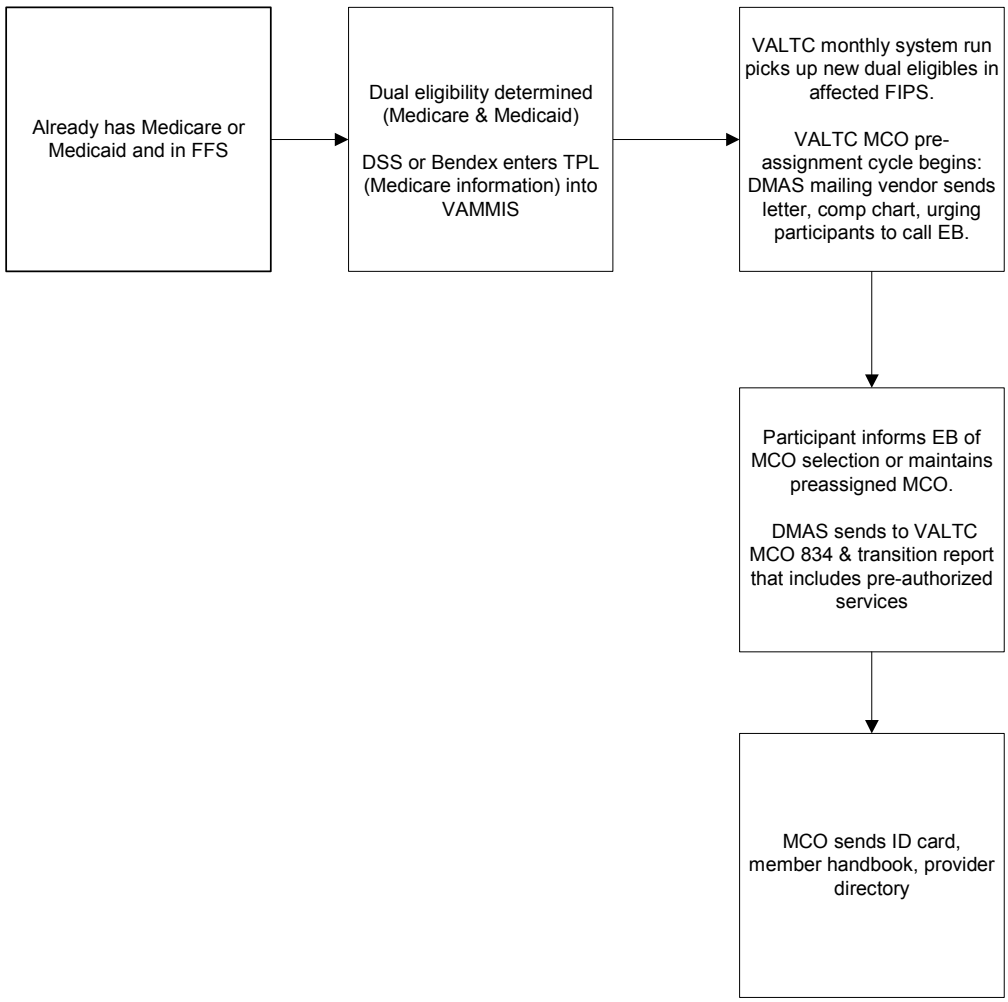
Last day of each month: VAMMIS auto closes waiver FFS prior authorized services effective 1 day prior to VALTC MCO enrollment - LOC file remains open.

VALTC MCO honors KePRO authorizations and conducts Transition of Care plan (face to face) within 90 days of enrollment or at annual LOC review (which ever comes first).

Recipient may need to switch service providers if initial LTC providers are not in the VALTC MCO's network

Dual Eligible

Dual Eligible: New to Medicaid ….OR… New to Medicare with current Medicaid FFS



Transition Report Contents:

Claims and Prior Authorization Data

New EDCD or New EDCD/Dual	Existing EDCD or Existing EDCD/Dual	Existing Duals or New Duals
File_Run_Date,	File_Run_Date,	File_Run_Date,
PLAN_PROV,	PLAN_PROV,	PLAN_PROV,
Record_type (clm vs PA),	Record_type (clm vs PA),	Record_type (clm vs PA),
RECIP_ID,	RECIP_ID,	RECIP_ID,
Recip_Last_NAME,	Recip_Last_NAME,	Recip_Last_NAME,
Recip_First_NAME,	Recip_First_NAME,	Recip_First_NAME,
Recip_MI_NAME,	Recip_MI_NAME,	Recip_MI_NAME,
Recip_PHONE,	Recip_PHONE,	Recip_PHONE,
Recip_BIRTH,	Recip_BIRTH,	Recip_BIRTH,
Recip_SEX,	Recip_SEX,	Recip_SEX,
Recip_FIPS,	Recip_FIPS,	Recip_FIPS,
Service_Type,	Service_Type,	Service_Type,
Diagnosis_Code,	Diagnosis_Code,	Diagnosis_Code,
Servicing_prov,	Servicing_prov,	Servicing_prov,
Servicing_Provider_NAME,	Servicing_Provider_NAME,	Servicing_Provider_NAME,
Provider_Class_Type,	Provider_Class_Type,	Provider_Class_Type,
Provider_Specialty,	Provider_Specialty,	Provider_Specialty,
Procedure_Code,	Procedure_Code,	Procedure_Code,
PA_num,	PA_num,	PA_num,
From_Dte,	From_Dte,	From_Dte,
as Thru_Dte,	as Thru_Dte,	as Thru_Dte,
PA_Auth_Units,	PA_Auth_Units,	PA_Auth_Units,
PA_Auth_Amnt,	PA_Auth_Amnt,	PA_Auth_Amnt,
Units,	Units,	Units,
Patient Pay Amount,	Patient Pay Amount,	
UAI Elements Entered into VAMMIS	UAI Elements Entered into VAMMIS	

APPENDIX C DMAS FORM-213 MCO For Newborns

COMMONWEALTH OF VIRGINIA

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

NEWBORN ELIGIBILITY NOTIFICATION
MCO USE ONLY
This document is the official notification of the child's birth for Medicaid enrollment.

ALL QUESTIONS MUST BE ANSWERED IN ORDER TO BE PROCESSED (Please Print Clearly)

***Mother's Name** _____
Last First M.I.

***Mother's SSN** ___ ___ ___ **Date of Birth** ___ ___ ___
M M D D Y Y

Mother's Address _____

_____

***Mother's Enrollee ID Number** ___ ___ ___ - ___ ___ ___ ___ ___ ___ - ___ ___ ___

Mother's Telephone Number, if known ___ ___ ___ - ___ ___ ___ - ___ ___ ___ ___

***Full Name of Newborn(s)** **Last** **First** **M.I.**	***Birth Date MM/DD/YY**	**Sex***	DSS Use Only MA Number Assigned
			___ ___ ___ - ___ ___ ___ ___ ___ ___ - ___ ___ ___
			___ ___ ___ - ___ ___ ___ ___ ___ ___ - ___ ___ ___
			___ ___ ___ - ___ ___ ___ ___ ___ ___ - ___ ___ ___

Note: Medicaid/FAMIS Plus eligibility for newborns begins on the date of birth, if the child is born to a Medicaid/FAMIS Plus eligible mother. Medicaid/FAMIS Plus newborns must be linked to their mother's case when enrolled in VAMMIS.

***Submitted by** _____ ***Signature** _____
a) **Name and title**

MCO Name _____ **Telephone #** ___ ___ ___ - ___ ___ ___ - ___ ___ ___ ___
b) MCO Address _____

_____ **MCO NPI/API ID#** ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

_____

MAIL FORM IMMEDIATELY TO:
Local Department of Social Services That Handles Mother's Case
*Mandatory

DSS Use Only
Date Received _____
Date Processed _____

APPENDIX D VALTC Live Birth Outcomes Report

MCO Name:_____
DATE: _____

MCO Name	Mother's Last Name	Mother's First Name	Mother's Medicaid Number	Mother's Effective Date in Plan	Mother's SSN or other ID Number	Mother enrolled in MCO's Prenatal Program?	Newborn's DOB	Newborn's Birth Weight (in grams)	Estimated Gestation period (in weeks)

APPENDIX E Summary of Integrated Acute Care Services

This attachment is not intended to be a comprehensive list of benefits. All benefit limits should be verified through the State Plan for Medicaid 12VAC30-50 and the appropriate DMAS Provider Manual.

Service	CFR, SPA or DMAS Manual Reference	A. Full Benefit Dual (Dual Eligible – QMB Plus)	B. Combination: Dual Eligible-QMB Plus with EDCD Waiver	C. EDCD Waiver (non Dual)	Notes
Abortions, induced	12 VAC 30-50-100 12 VAC 30-50-180 42 C.F.R. § 441.203 and § 441.206 http://websrvr.dmas.virginia.gov/manuals/phy/chapterIV_phy.pdf	No	No	No	**The MCO is not required to cover services for abortion**. **This service will be covered through a carve out.** Requests for abortions where the life of the mother is endangered shall be forwarded to the Department for review to ensure compliance with Federal Medicaid rules. The Department will be responsible for payment of abortion services meeting Federal Medicaid requirements under the fee-for-service program.
Case Management Services for Recipients of Auxiliary Grants	12 VAC 30-50-470 12VAC30-10-320 http://websrvr.dmas.virginia.gov/manuals/als/chapteriv_als.pdf	Yes (pursuant to 12VAC30-10-320)	Yes (pursuant to 12VAC30-10-320)	Yes	**The MCO is not required to cover this service. This service will be covered through a carve out.** This service will continue to be covered through the DMAS fee-for-service system.
Case Management Services for the Elderly	12 VAC 30-50-460 http://websrvr.dmas.virginia.gov/manuals/ECMS/Chapter4_ecms.pdf	No	No	No	**The MCO is not required to cover this service.** Upon implementation of VALTC, this service will no longer be available in the VALTC pilot area.
Chiropractic Services	12 VAC 30-50-150	No	No	No	This service is not a Medicaid covered service. **The MCO is not required to cover this service.**
Christian Science Nurses and Christian Science Sanatoria	12 VAC 30-50-300	No	No	No	This service is not a Medicaid covered service. **The MCO is not required to cover this service.**
Clinic Services	12 VAC 30-50-180 http://websrvr.dmas.virginia.gov/manuals/phy/chapterIV_phy.pdf	Yes (pursuant to 12VAC30-10-320)	Yes (pursuant to 12VAC30-10-320)	Yes	The MCO shall cover all clinic services which are defined as preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are provided to outpatients and are provided by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients. With the exception of nurse-midwife services, clinic services are furnished under the direction of a physician. Renal dialysis clinic visits are also covered.
Colorectal Cancer Screening	12 VAC 30-50-220	Yes (pursuant to 12VAC30-10-320)	Yes (pursuant to 12VAC30-10-320)	Yes	The MCO shall cover colorectal cancer screening in accordance with the most recently published recommendations established by the American Cancer Society, for the ages, family histories and frequencies referenced in such recommendations.

Service	CFR, SPA or DMAS Manual Reference	A. Full Benefit Dual (Dual Eligible – QMB Plus)	B. Combination: Dual Eligible-QMB Plus with EDCD Waiver	C. EDCD Waiver (non Dual)	Notes
Court Ordered Services	Code of Virginia Section 37.1-67.4	Yes (pursuant to 12VAC30-10-320)	Yes (pursuant to 12VAC30-10-320)	Yes	The MCO shall cover all medically necessary court ordered ALTC covered services. In the absence of a contract otherwise, out-of-network payments will be made in accordance with the Medicaid fee schedule.
Dental Services **(ADULT)**	12 VAC 30-50-190 38.2-341.12 of the Code of Virginia http://websrvr.dmas.virginia.gov/manuals/den/dentoc.htm	No, except for certain circumstances. See notes.	No, except for certain circumstances. See notes.	Adults: No except for certain circumstances.	**This service will be covered through a carve out.** The MCO shall cover CPT codes billed by an MD as a result of an accident. The MCO shall cover CPT and other "non-CDT" procedure codes billed for medically necessary procedures of the mouth for adults and children. The MCO shall cover medically necessary anesthesia and hospitalization services for certain individuals when determined such services are required to provide dental care. Optional: The MCO, at its option, may cover certain dental services as for VALTC participants.
Dental Services **(CHILD – 21 and under)**	http://websrvr.dmas.virginia.gov/manuals/den/dentoc.htm	Children: Covered through a carve out. (pursuant to 12VAC30-10-320)	Children: Covered through a carve out. (pursuant to 12VAC30-10-320)	Children: Covered through a carve out.	**This service will be covered through a carve out.** Above notes apply as relevant. The MCO shall assure it has processes in place to refer enrollees seeking routine dental services to the dental contractor. The MCO shall be responsible for transportation and medication related to dental services.

Service	CFR, SPA or DMAS Manual Reference	A. Full Benefit Dual (Dual Eligible – QMB Plus)	B. Combination: Dual Eligible-QMB Plus with EDCD Waiver	C. EDCD Waiver (non Dual)	Notes
Early and Periodic Screening, Diagnosis and Treatment (EPSDT) (Newborns 0-3 months only)	12 VAC 30-50-130 http://websrvr.dmas.virginia.gov/manuals/General/epsdt_supplement_gen.pdf http://websrvr.dmas.virginia.gov/manuals/General/epsdt_supplement_gen.pdf http://websrvr.dmas.virginia.gov/manuals/General/EPSDT_pcs.pdf http://websrvr.dmas.virginia.gov/manuals/General/prm-EPSDT_Hear_Audio.pdf	Yes (pursuant to 12VAC30-10-320)	Yes (pursuant to 12VAC30-10-320)	Yes	The MCO shall cover EPSDT screenings **(including lead screenings)** and diagnostic services as well as any and all services identified as necessary to correct or ameliorate any identified defects or chronic conditions. (Some services may require prior authorization).The MCO shall screen and assess all newborns 0-3 months. The MCO shall cover immunizations. The MCO shall educate providers regarding reimbursement of immunizations and to work with the Department to achieve its goal related to increased immunization rates. In addition to the traditional review for medical necessity, children who are denied services under Medicaid must receive a secondary review to ensure that the EPSDT provision has been considered. The MCO's secondary review process for medical necessity shall not exceed the EPSDT correct or ameliorate criteria. Denial for services to children cannot be given until this secondary review has been completed. The MCO shall establish a process approved in advance by the Department which allows providers to contact case managers to explore alternative services, therapies, and resources for members when necessary.

Service	CFR, SPA or DMAS Manual Reference	A. Full Benefit Dual (Dual Eligible – QMB Plus)	B. Combination: Dual Eligible-QMB Plus with EDCD Waiver	C. EDCD Waiver (non Dual)	Notes
Early Intervention (Newborns 0- 3 months)	Virginia Code § 2.2-5300 12VAC30-130-10 and 12VAC30-50-200 http://websrvr.dmas.virginia.gov/manuals/BC/chapter4_bc.PDF	Yes (pursuant to 12VAC30-10-320)	Yes (pursuant to 12VAC30-10-320)	**Yes**	The MCO shall cover all medically necessary, Medicaid covered services for children from birth to three months, who are determined eligible for Part C services of the Individuals with Disabilities Act by the Department of Mental Health Mental Retardation and Substance Abuse Services or applicable Early Intervention Interagency Council. The MCO shall cover medically necessary services, including rehabilitative therapies within the amount duration and scope as defined in 12VAC30-130-10 and 12VAC30-50-200. All services shall be specific and provide effective treatment for the patent's condition in accordance with accepted standards of medical practice; this includes the requirement that the amount, frequency, and duration of the services shall be reasonable. The MCO or its designated subcontractor may require prior authorization of services for the purposes of determining medical necessity of therapies and services.

Service	CFR, SPA or DMAS Manual Reference	A. Full Benefit Dual (Dual Eligible – QMB Plus)	B. Combination: Dual Eligible-QMB Plus with EDCD Waiver	C. EDCD Waiver (non Dual)	Notes
Emergency Services	12 VAC 30-50-110 12 VAC 30-50- 12 VAC 30-50-300 12 VAC 30-120-395 42 C.F.R. § 434.30 42 CFR §438.114 http://websrvr.dmas.virginia.gov/manuals/phy/chapterIV_phy.pdf	Yes (pursuant to 12VAC30-10-320)	Yes (pursuant to 12VAC30-10-320)	Yes	In accordance with 42 C.F.R. § 434.30, the MCO shall ensure that all covered emergency services are available, without requiring prior authorization, twenty-four (24) hours a day and seven (7) days a week through the MCO's network. The MCO shall cover all emergency services without prior authorization. The MCO shall cover the services needed to ascertain whether an emergency exists and to stabilize the patient. The MCO may not retroactively deny a claim for an emergency screening examination because the condition, which appeared to be an emergency medical condition under the "prudent layperson" standard, as defined herein, was in fact non-emergency in nature. The MCO shall cover those medical examinations performed in emergency departments for enrolled children as part of a child protective services investigation. In the absence of a contract otherwise, these services shall be reimbursed at the applicable Virginia Medicaid fee-for-service program rate in effect at the time the service was rendered. The MCO may not restrict an enrollee's choice of provider for emergency services. In the absence of a contract or otherwise, all claims for emergency services shall be reimbursed at the applicable Medicaid fee-for-service program rate in effect at the time the service was rendered. Required payments for emergency services are summarized 12 VAC 30-50-300, 12 VAC 30-50-310, and 12VAC 30-120-395.

Service	CFR, SPA or DMAS Manual Reference	A. Full Benefit Dual (Dual Eligible – QMB Plus)	B. Combination: Dual Eligible-QMB Plus with EDCD Waiver	C. EDCD Waiver (non Dual)	Notes
Emergency Services - Post Stabilization Care	42 C.F.R. 422.100(b)(1)(iv) 42 CFR § 422.113(c)	Yes (pursuant to 12VAC30-10-320)	Yes (pursuant to 12VAC30-10-320)	Yes	The MCO shall pay for all emergency services which are medically necessary until the clinical emergency is stabilized and until the patient can be safely discharged or transferred. This shall include payment for post stabilization care; or services provided subsequent to an emergency that a treating physician views as medically necessary after an emergency medical condition has been stabilized. Coverage shall include treatment that may be necessary to assure, within reasonable medical probability that no material deterioration of the patient's condition is likely to result from, or occur during, discharge of the patient or transfer of the patient to another facility.
Experimental and Investigational Procedures	12 VAC 30-50-140 http://websrvr.dmas.virginia.gov/manuals/phy/chapterIV_phy.pdf	No	No	No	**This service is not a Medicaid covered service.**

Service	CFR, SPA or DMAS Manual Reference	A. Full Benefit Dual (Dual Eligible – QMB Plus)	B. Combination: Dual Eligible-QMB Plus with EDCD Waiver	C. EDCD Waiver (non Dual)	Notes
Family Planning Services	12 VAC 30-50-130 42C.F.R. § 441.20 42 C.F.R. § 431.51(b)(2) http://websrvr.dmas.virginia.gov/manuals/BC/chapter4_bc.PDF	Yes (pursuant to 12VAC30-10-320)	Yes (pursuant to 12VAC30-10-320)	Yes	The MCO shall cover all family planning services and supplies for individuals of child-bearing age which delay or prevent pregnancy, including drugs, supplies and devices. The MCO may not restrict an enrollee's choice of provider for family planning services or supplies, and the MCO shall cover all family planning services and supplies provided to its enrollees by network providers and by out-of-network providers. Federal law (42CFR § 441.20) requires that the MCO also allow the recipient, free from coercion or mental pressure, the freedom to choose the method of family planning to be used. The MCO shall not perform sterilization for an enrollee under age twenty-one (21). The MCO shall comply with the requirements set forth in 42 C.F.R. § 441, Subpart F, as amended, and shall comply with the thirty (30) calendar day waiting period requirement as specified in Code of Virginia, § 54.1-2974. The MCO may not impose a 30-day waiting period for hysterectomies that are not performed for rendering sterility. Hysterectomies performed solely for the purpose of rendering an individual incapable of reproducing are not covered by Medicaid. The Department's Family Planning Program as approved in the 1115 Waiver by the Centers for Medicare and Medicaid Services is not covered under the VALTC program.
General Obstetrical Hospital Services	12 VAC 30-50-100 http://websrvr.dmas.virginia.gov/manuals/phy/chapterIV_phy.pdf	Yes (pursuant to 12VAC30-10-320)	Yes (pursuant to 12VAC30-10-320)	Yes	The length of stay for vaginal and cesarean births shall be consistent with 12 VAC 30-50-100 including provisions for early discharge and home visits as set forth in 12 VAC 30-50-220.

Service	CFR, SPA or DMAS Manual Reference	A. Full Benefit Dual (Dual Eligible – QMB Plus)	B. Combination: Dual Eligible-QMB Plus with EDCD Waiver	C. EDCD Waiver (non Dual)	Notes
High-Risk Prenatal and Infant Services Program	12 VAC 30-50-280 12 VAC 30-50-290 12 VAC 30-50-510 12 VAC 30-50-410 http://websrvr.dmas.virginia.gov/manuals/BC/chapter4_bc.PDF	Yes (pursuant to 12VAC30-10-320)	Yes (pursuant to 12VAC30-10-320)	Yes	Provide or arrange for services for pregnant women and children up to age 2. These services shall address the following major goals: To reduce infant mortality and morbidity; To ensure provision of comprehensive services to pregnant women, postpartum women, infants and toddlers up to age two (2); and To assist pregnant and postpartum women and caregivers of infants in meeting other priority needs that affect their well-being and that of their families. These needs may include non-medical needs and non-covered services. Program services shall include, at a minimum, the following: Case management services for high-risk pregnant women and children that include coordination of services for maternal and child health to minimize fragmentation of care, reduce barriers, and link recipients with appropriate services to ensure comprehensive, continuous health care. These coordination services will include: a. Assessment to determine recipients' needs which includes psychosocial, nutrition, and medical factors. b. Service planning to develop individualized descriptions of what services and resources are needed to meet the service needs of the client and how to access those resources. c. Coordination and referrals that will assist the client in arranging for appropriate services and ensure continuity of care. d. The MCO shall develop and offer expanded prenatal care services for all pregnant women comparable to those described in 12 VAC 30-50-510 and 12 VAC 30-50-290. They shall provide a comprehensive prenatal care service package which may include services such as patient education, homemaker services, nutritional assessment and counseling, and provision of blood glucose meters when medically necessary.

Service	CFR, SPA or DMAS Manual Reference	A. Full Benefit Dual (Dual Eligible – QMB Plus)	B. Combination: Dual Eligible-QMB Plus with EDCD Waiver	C. EDCD Waiver (non Dual)	Notes
HIV Testing and Treatment Counseling	Code of Virginia Section 54.1-2403.01 http://websrvr.dmas.virginia.gov/manuals/phy/chapterIV_phy.pdf	Yes (pursuant to 12VAC30-10-320)	Yes (pursuant to 12VAC30-10-320)	Yes	The MCO shall comply with the State requirements governing HIV testing and treatment counseling for pregnant women. The MCO shall ensure that, as a routine component of prenatal care, every pregnant enrollee shall be advised of the value of testing for HIV infection as set forth in 12 VAC 30-50-510 and shall request of each such pregnant enrollee consent to testing as set forth in § 54.1-2403.01 of the Code of Virginia. Any pregnant enrollee shall have the right to refuse consent to testing for HIV infection and any recommended treatment. Documentation of such refusal shall be maintained in the enrollee's medical record.

Service	CFR, SPA or DMAS Manual Reference	A. Full Benefit Dual (Dual Eligible – QMB Plus)	B. Combination: Dual Eligible-QMB Plus with EDCD Waiver	C. EDCD Waiver (non Dual)	Notes
Home Health Services	12 VAC 30-50-160 http://websrvr.dmas.virginia.gov/manuals/HH/chapterIV_hh.pdf	Yes (pursuant to 12VAC30-10-320)	Yes (pursuant to 12VAC30-10-320)	Yes	The MCO shall cover home health services, including nursing services, rehabilitation therapies, and home health aide services. Visits by a licensed nurse and home health aide services shall be covered as medically necessary. Rehabilitation services (physical therapy, occupational therapy, and speech-language therapy) shall also be covered under the enrollee's home health benefit. The MCO must manage the following service related conditions, where medically necessary and regardless of whether the need is long-term or short-term: B-12 shots, insulin injections, central line and porta cath flushes, blood draws for example where the recipient is medically unstable or is morbidly obese and requires transportation via lab/MD office by ambulance, changing of indwelling catheter. This includes those instances where the member cannot perform the services; where there is no responsible party willing and able to perform the services, and where and the service cannot be performed in the PCP office/outpatient clinic, etc. The MCO may cover these services under home health or may choose to manage the related conditions using another safe and effective treatment option. The MCO shall not refer for skilled nursing under the home and community based waivers for these conditions. **The MCO is not required to cover** the following home health services, except if ordered by a physician as a result of an EPSDT screen or high-risk pregnancy screen: medical social services, services that would not be paid for by Medicaid if provided to an inpatient of a hospital, community food service delivery arrangements, domestic or housekeeping services which are unrelated to patient care, custodial care which is patient care that primarily requires protective services rather than definitive medical and skilled nursing care services, and services related to cosmetic surgery.

Service	CFR, SPA or DMAS Manual Reference	A. Full Benefit Dual (Dual Eligible – QMB Plus)	B. Combination: Dual Eligible-QMB Plus with EDCD Waiver	C. EDCD Waiver (non Dual)	Notes
Hospice Services	12 VAC 30-50-270 http://websrvr.dmas.virginia.gov/manuals/HSPC/chapterIV_hspc.pdf	No	No	No	**The MCO is not required to cover this service.** This service will continue to be covered through the DMAS fee-for-service system. DMAS authorization into hospice services will result in disenrollment of the recipient from VALTC.
Immunizations	12 VAC 30-50-130 http://websrvr.dmas.virginia.gov/manuals/phy/chapterIV_phy.pdf http://websrvr.dmas.virginia.gov/manuals/General/epsdt_supplement_gen.pdf	Yes (pursuant to 12VAC30-10-320)	Yes (pursuant to 12VAC30-10-320)	Yes	The MCO shall cover immunizations in accordance with the EPSDT periodicity schedule specified in the most current Advisory Committee on Immunization Practices (ACIP) Recommendations, concurrently with the conduct of the EPSDT screening and that enrollees are not inappropriately referred to other providers for immunizations. The MCO shall educate providers regarding reimbursement of immunizations and to work with the Department to achieve its goal related to increased immunization rates. The MCO shall encourage all PCPs who administer childhood immunizations to enroll in the Virginia Vaccines for Children Program, administered by the Virginia Department of Health. The capitation rate paid to the MCO shall include the fee for the administration of the vaccines.
Inpatient Hospital Services	12 VAC 30-50-100 12 VAC 30-50-105 12 VAC 30-80-115 12 VAC 30-50-220 Chapter 709 of the 1998 Virginia Acts of Assembly § 32.1-325(A) http://websrvr.dmas.virginia.gov/manuals/HOS/chapter4_HOS.pdf	Yes (pursuant to 12VAC30-10-320)	Yes (pursuant to 12VAC30-10-320)	Yes	The MCO shall cover inpatient stays in general acute care and rehabilitation hospitals for all enrollees. The MCO shall comply with maternity length of stay requirements. MCO shall comply with radical or modified radical mastectomy, total or partial mastectomy length of stay requirements. The MCO shall cover an early discharge follow-up visit if the mother and newborn, or the newborn alone, are discharged earlier than 48 hours after the day of delivery.

Service	CFR, SPA or DMAS Manual Reference	A. Full Benefit Dual (Dual Eligible – QMB Plus)	B. Combination: Dual Eligible-QMB Plus with EDCD Waiver	C. EDCD Waiver (non Dual)	Notes
Inpatient Rehabilitation Hospitals	12 VAC 30-50-200 and 12 VAC 30-50-225 http://websrvr.dmas.virginia.gov/manuals/reb/chapterIV_reb.pdf	Yes (pursuant to 12VAC30-10-320)	Yes (pursuant to 12VAC30-10-320)	Yes	The MCO shall cover inpatient rehabilitation services in facilities certified as rehabilitation hospitals and rehabilitation hospitals which have been certified by the Department of Health to meet the requirements to be excluded from the Medicare Prospective Payment System.
Laboratory and X-ray Services	12 VAC 30-50-120 http://websrvr.dmas.virginia.gov/manuals/IL/chapterIV_il.pdf	Yes (pursuant to 12VAC30-10-320)	Yes (pursuant to 12VAC30-10-320)	Yes	The MCO shall cover laboratory and x-ray services ordered, prescribed and directed or performed within the scope of the license of a practitioner of the healing arts. All laboratory testing sites providing services under this Contract must have Clinical Laboratory Improvement Amendments (CLIA) certification and either a clinical laboratory license, a certification of waiver, or a certificate of registration and an identification number. Those laboratories with certificates of waiver will provide only the types of tests permitted under the terms of the waiver. Laboratories with certificates of registration may perform the full range of services for which they are certified.
Lead Investigations	12 VAC 30-50-227 http://websrvr.dmas.virginia.gov/manuals/General/epsdt_supplement_gen.pdf	No	No	No	**The MCO is not required to cover this service**. **This service will be covered through a carve out.** This service will continue to be covered through the DMAS fee-for-service system.
Mammograms	12 VAC 30-50-220 http://websrvr.dmas.virginia.gov/manuals/IL/chapterIV_il.pdf http://websrvr.dmas.virginia.gov/manuals/phy/chapterIV_phy.pdf	Yes (pursuant to 12VAC30-10-320)	Yes (pursuant to 12VAC30-10-320)	Yes	The MCO shall cover low-dose screening mammograms for determining presence of occult breast cancer for female enrollees age thirty-five (35) and over, consistent with the guidelines published by the American Cancer Society.

Service	CFR, SPA or DMAS Manual Reference	A. Full Benefit Dual (Dual Eligible – QMB Plus)	B. Combination: Dual Eligible-QMB Plus with EDCD Waiver	C. EDCD Waiver (non Dual)	Notes
Medical Supplies and Equipment	12 VAC 30-50-160 12 VAC 30-50-165 12VAC30-120-195 http://websrvr.dmas.virginia.gov/manuals/DME/dmetoc.htm	Yes (pursuant to 12VAC30-10-320)	Yes (pursuant to 12VAC30-10-320)	Yes	The MCO shall cover all medical supplies and equipment at least to the extent they are covered by DMAS. The MCO is responsible for payment of any specially manufactured DME equipment that was prior authorized by the MCO, even if the member is no longer enrolled with the plan or with Medicaid. Retraction of the payment for specialized equipment can only be made if the member is retro-disenrolled for any reason by the Department and the effective date of the retro-disenrollment precedes the date the equipment was authorized by the MCO. The Department and all Contractors must use the valid preauthorization begin date as the invoice date. Specialized equipment includes, but is not limited to, the following: i. Customized wheelchairs and required components; ii. Customized prone standers; and, iii. Customized positioning devices Coverage of enteral nutrition (EN) and total parenteral nutrition (TPN) which do not include a legend drug is only required when the nutritional supplement is the sole-source form of nutrition (except for enrollees under age twenty-one (21), where the supplement must be the primary source of nutrition), is administered orally or through nasogastric or gastrotomy tube, and is necessary to treat a medical condition. Coverage of enteral nutrition and total parenteral nutrition shall not include the provision of routine infant formula. Specialized infant formula for children under age 5 is **carved out** of this contract and reimbursed by the Department. Medical foods for enrollees under 21 are **carved out.**

Service	CFR, SPA or DMAS Manual Reference	A. Full Benefit Dual (Dual Eligible – QMB Plus)	B. Combination: Dual Eligible-QMB Plus with EDCD Waiver	C. EDCD Waiver (non Dual)	Notes
Nurse-Midwife Services	12 VAC 30-50-260	Yes (pursuant to 12VAC30-10-320)	Yes (pursuant to 12VAC30-10-320)	Yes	The MCO shall cover nurse-midwife services as allowed under State licensure requirements and Federal law.
Nursing Facility	12VAC5-215-10 12 VAC 30-50-130 http://websrvr.dmas.virginia.gov/manuals/NH/ChapterIV_nh.pdf	Yes (pursuant to 12VAC30-10-320)	Yes (pursuant to 12VAC30-10-320)	Yes	The MCO shall cover all medically necessary services provided in a nursing facility for a period of 60 days from the date of admission to the nursing facility. If the beneficiary remains in the nursing facility upon completion of the 60-day period, the beneficiary shall be disenrolled from the health plan and shall begin receiving services under the traditional fee-for-service (FFS) program. While the VALTC managed care organization (MCO) shall be responsible for the cost of nursing facility care during this 60-day period, payment for services shall be made directly from DMAS in a manner that is identical to payment made under the FFS program. During the 60-day managed care coverage period, the VALTC MCO shall be responsible for non-nursing home services and shall work with the nursing home on discharge planning if appropriate. The MCO may provide additional health care improvement services or other services not specified in this contract, including but not limited to step down nursing care as long as these services are available, as needed or desired, to enrollees. Should a managed care organization seek to utilize nursing facility services for plan beneficiaries that would not otherwise meet Medicaid nursing facility coverage criteria, these services would not be subject to the above provisions and would create the necessity for a contractual arrangement, including the establishment of payment rates and claims payment provisions, between the MCO and the nursing facility.

Service	CFR, SPA or DMAS Manual Reference	A. Full Benefit Dual (Dual Eligible – QMB Plus)	B. Combination: Dual Eligible-QMB Plus with EDCD Waiver	C. EDCD Waiver (non Dual)	Notes
Obstetric and Gynecologic Services	http://websrvr.dmas.virginia.gov/manuals/phy/chapterIV_phy.pdf	Yes (pursuant to 12VAC30-10-320)	Yes (pursuant to 12VAC30-10-320)	Yes	The MCO shall permit any female enrollee of age thirteen (13) or older direct access, as provided in subsection B of § 38.2-3407.11 of the Code of Virginia, to a participating obstetrician-gynecologist for annual examinations and routine health care services, including pap smears, without prior authorization from the primary care physician. Routine and medically necessary obstetric and gynecologic (OB/GYN) health care services covered under Medicaid for covered individuals. Health care services means the full scope of medically necessary services provided by the obstetrician-gynecologist in the care of or related to the female reproductive system in accordance with the most current published recommendations of the American College of Obstetricians and Gynecologists. The MCO shall reimburse OB/GYN services at least the amount reimbursed under the Medicaid fee schedule.

Service	CFR, SPA or DMAS Manual Reference	A. Full Benefit Dual (Dual Eligible – QMB Plus)	B. Combination: Dual Eligible-QMB Plus with EDCD Waiver	C. EDCD Waiver (non Dual)	Notes
Organ Transplantation	12 VAC 30-50-540 through 12 VAC 30-50-580, and 12 VAC 30-10-280 12 VAC 30-50-100G 12 VAC 30-50-105K	Yes (pursuant to 12VAC30-10-320)	Yes (pursuant to 12VAC30-10-320)	Yes	Organ transplantation services for kidneys and corneas for all eligible individuals, regardless of age. The MCO shall cover services for bone marrow transplants and high-dose chemotherapy for adult (age twenty-one (21) or over) enrollees diagnosed with breast cancer, leukemia, lymphoma and myeloma. The MCO shall cover liver, heart, and any other medically necessary transplant procedures for enrollees up to age twenty-one (21). The MCO shall cover liver, heart and lung transplantation procedures for individuals over the age of 21 years when medically necessary. Coverage of liver transplants (for adults and children) includes coverage for partial or whole, and orthotopic or heterotopic liver transplantation, from cadaver or living donor (and for individuals meeting the criteria). The MCO must use Department prior authorization criteria or other medically sound, scientifically based criteria in accordance with national standards in making medical necessity determinations for all transplantations. The MCO is not required to cover transplant procedures determined to be experimental or investigational. However, scheduled transplantations authorized by DMAS must be honored by the MCO, as with all authorizations, until such time that DMAS can disenroll the enrollee from the MCO, if applicable, if the transplant is scheduled to occur concurrent with the recipient's enrollment with the MCO. Any medically necessary transplants that are not experimental or investigational are covered for children under 21 years of age, when preauthorized.

Service	CFR, SPA or DMAS Manual Reference	A. Full Benefit Dual (Dual Eligible – QMB Plus)	B. Combination: Dual Eligible-QMB Plus with EDCD Waiver	C. EDCD Waiver (non Dual)	Notes
Outpatient Hospital Services	12 VAC 30-50-110	Yes (pursuant to 12VAC30-10-320)	Yes (pursuant to 12VAC30-10-320)	Yes	The MCO shall cover outpatient hospital services which are preventive, diagnostic, therapeutic, rehabilitative or palliative in nature that are furnished to outpatients, except in the case of nurse-midwife services that are furnished under the direction of a physician, and are furnished by either a rural health center (RHC), a Federally Qualified Health Center (FQHC), or an institution that is licensed or formally approved as a hospital by an officially designated authority for State standard-setting and meets the requirements for participation in Medicare, as set forth in 12 VAC 30-50-110. Observation bed services shall be covered when they are reasonable and necessary to evaluate a medical condition to determine appropriate level of treatment or non-routine observation for underlying medical complications. These services must be billed as outpatient care and may be provided for up to 23 hours. A patient stay of 24 hours or more shall require inpatient pre-certification and admission.
Pap Smears	12 VAC 30-50-220 http://websrvr.dmas.virginia.gov/manuals/phy/chapterIV_phy.pdf	Yes (pursuant to 12VAC30-10-320)	Yes (pursuant to 12VAC30-10-320)	Yes	MCO shall cover annual pap smears

Service	CFR, SPA or DMAS Manual Reference	A. Full Benefit Dual (Dual Eligible – QMB Plus)	B. Combination: Dual Eligible-QMB Plus with EDCD Waiver	C. EDCD Waiver (non Dual)	Notes
Physical Therapy, Occupational Therapy, Speech Pathology and Audiology Services	12 VAC 30-50-160 12 VAC 30-50-200 12VAC30-130-40 12 VAC 30-50-225 http://websrvr.dmas.virginia.gov/manuals/reb/chapterIV_reb.pdf	Yes (pursuant to 12VAC30-10-320)	Yes (pursuant to 12VAC30-10-320)	Yes	The MCO shall cover physical therapy (PT), occupational therapy (OT), and speech-language pathology (SLP), and audiology services. The scope of coverage for Medicaid specifically includes coverage for both acute and non-acute conditions. Medicaid regulations define "acute conditions" as conditions that are expected to be of brief duration (less than 12 months) in which progress toward goals is likely to occur frequently. "Non-acute conditions" are defined as conditions that are of long duration (greater than 12 months) in which progress toward established goals is likely to occur slowly. PT, OT, SLP, and audiology services are covered regardless of where they are provided, with two exceptions. The MCO shall be required to cover services rendered in a nursing facility if the services are not offered as an in-house component of the facility. The MCO shall also cover all medically necessary, intensive outpatient physical rehabilitation services in facilities which are certified as Comprehensive Outpatient Rehabilitation Facilities (CORFs).
Physician Services	12 VAC 30-50-140 http://websrvr.dmas.virginia.gov/manuals/phy/chapterIV_phy.pdf	Yes (pursuant to 12VAC30-10-320)	Yes (pursuant to 12VAC30-10-320)	Yes	The MCO shall cover all Symptomatic visits provided by physicians or physician extenders within the scope of their licenses. Cosmetic services are not covered unless performed for medically necessary physiological reasons. The MCO is only required to cover routine physicals when the services are provided under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program. The MCO is strongly encouraged to cover routine physicals for enrollees not covered through the EPSDT program.

Service	CFR, SPA or DMAS Manual Reference	A. Full Benefit Dual (Dual Eligible – QMB Plus)	B. Combination: Dual Eligible-QMB Plus with EDCD Waiver	C. EDCD Waiver (non Dual)	Notes
Podiatry	12 VAC 30-50-150 http://websrvr.dmas.virginia.gov/manuals/POD/chapterIV_pod.pdf	Yes (pursuant to 12VAC30-10-320)	Yes (pursuant to 12VAC30-10-320)	Yes	The MCO shall cover podiatric services that are defined as reasonable and necessary diagnostic, medical, or surgical treatment of disease, injury, or defects of the human foot. The MCO is not required to cover preventive health care, including routine foot care; treatment of structural misalignment not requiring surgery; cutting or removal of corns, warts, or calluses; experimental procedures; or acupuncture.

Service	CFR, SPA or DMAS Manual Reference	A. Full Benefit Dual (Dual Eligible – QMB Plus)	B. Combination: Dual Eligible-QMB Plus with EDCD Waiver	C. EDCD Waiver (non Dual)	Notes
Pregnancy-Related Services	12 VAC 30-50-220 12 VAC 30-50-280 12 VAC 30-50-290 12 VAC 30-50-410	Yes (pursuant to 12VAC30-10-320)	Yes (pursuant to 12VAC30-10-320)	Yes	The MCO shall cover services to pregnant women, including: a. Pregnancy-related and postpartum services for sixty (60) calendar days after the pregnancy ends, as set forth in 12 VAC 30-50-290; b. Services to treat any other medical condition that may complicate pregnancy, as set forth in 12 VAC 30-50-290; c. Prenatal services, including patient education, nutritional assessment, counseling and homemaker services, as set forth in 12 VAC 30-50-510 and 12 VAC 30-50-290; d. Case management services for high-risk pregnant women and infants up to age two (2), as set forth in 12 VAC 30-50-410 and 12 VAC 30-50-280. Case management services for neonatal intensive care. In cases in which the newborn and mother or the newborn alone are discharged earlier than forty-eight (48) hours after the day of delivery, the MCO shall cover at least one (1) early discharge follow-up visit as indicated by the most recent "Guidelines for Perinatal Care" developed by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists. The early discharge follow-up visit shall be provided to all mothers and newborns or the newborn alone, if the mother has not been discharged, who meet the Department's criteria for early discharge, as set forth in 12 VAC 30-50-220.The early discharge follow-up visit shall be provided within forty-eight (48) hours of discharge and must include, at a minimum, a maternal assessment and a newborn assessment, as set forth in 12 VAC 30-50-220.

Service	CFR, SPA or DMAS Manual Reference	A. Full Benefit Dual (Dual Eligible – QMB Plus)	B. Combination: Dual Eligible-QMB Plus with EDCD Waiver	C. EDCD Waiver (non Dual)	Notes
Prescription Drugs	12 VAC 30-50-210 12 VAC 30-50 §38.2-4312.1 of the Code of Virginia http://websrvr.dmas.virginia.gov/manuals/RX/chapterIV_rx.pdf	Yes (pursuant to 12VAC30-10-320 and in coordination with Medicare Part D)	Yes (pursuant to 12VAC30-10-320 and in coordination with Medicare Part D)	Yes	The MCO shall cover all Medicaid covered prescription drugs prescribed by providers licensed and/or certified as having authority to prescribe the drug including those prescribed by a provider during a physician visit or other visit covered by a third party payer including Mental Health visits. . The MCO is not required to cover Drug Efficacy Study Implementation (DESI) drugs. The MCO may establish a formulary and shall have in place authorization procedures to allow providers to access drugs outside of this formulary, if medically necessary and if Medicaid would cover them for fee-for-service enrollees. If the drug is prescribed for an "emergency medical condition," the MCO must pay for at least a 72-hour supply of the drug to allow the MCO time to make a decision. The MCO shall cover therapeutic drugs even when they are prescribed as a result of non-covered services or carved-out services (e.g., narcotic analgesics after cosmetic surgery). The MCO shall cover atypical antipsychotic medications developed for the treatment of schizophrenia. The MCO is responsible for coverage of specific drug classes that are excluded by law under the Medicare Part D but covered under the currently established guidelines of the DMAS pharmacy benefit program. Drugs for the treatment of erectile dysfunction are not covered by Medicaid. The MCO may impose co-payments on payments on prescription drugs, except for family planning or pregnancy related medications and any medications provided to children.

Service	CFR, SPA or DMAS Manual Reference	A. Full Benefit Dual (Dual Eligible – QMB Plus)	B. Combination: Dual Eligible-QMB Plus with EDCD Waiver	C. EDCD Waiver (non Dual)	Notes
Private Duty Nursing	42CFR441.50 and 1905(a) of Social Security Act http://websrvr.dmas.virginia.gov/manuals/General/EPSDT_Nursing.pdf;	Not covered for Adults. Coverage is available for children under age 21 under EPSDT.	Not covered for Adults. Coverage is available for children under age 21 under EPSDT.	Not covered for Adults. Coverage is available for children under age 21 under EPSDT.	The MCO is required to cover medically necessary private duty nursing services for newborns 0-3 months consistent with the Department's criteria described in the EPSDT Nursing Supplement, available on the DMAS website at: http://websrvr.dmas.virginia.gov/manuals/General/EPSDT_Nursing.pdf
Prostate Specific Antigen (PSA) and digital rectal exams	12 VAC 30-50-220 http://websrvr.dmas.virginia.gov/manuals/phy/chapterIV_phy.pdf	Yes (pursuant to 12VAC30-10-320)	Yes (pursuant to 12VAC30-10-320)	Yes	The MCO shall cover screening Prostate Specific Antigen (PSA) and the related digital rectal exams (DRG) for the screening of male enrollees for prostate cancer.
Prosthetics/Orthotics	12 VAC 30-50-210 12 VAC 30-60-120 http://websrvr.dmas.virginia.gov/manuals/PD/chapterIV_pd.pdf	Yes (pursuant to 12VAC30-10-320)	Yes (pursuant to 12VAC30-10-320)	Yes	The MCO shall cover Medically necessary prosthetic and orthotic services and devices. Coverage for prosthetics includes artificial arms, legs and their necessary supportive attachments, internal body parts (implants), breasts, and eye prostheses when eyeballs are missing and regardless of the function of the eye. The MCO shall cover medically necessary orthotics (i.e., braces, splints, ankle, foot orthoses, etc.) for newborns 0-3 months. The MCO shall cover medically necessary prosthetics and orthotics for an enrollee regardless of the enrollee's age when recommended as part of an approved intensive rehabilitation program.
Prostheses, Breast	12 VAC 30-50-210 http://websrvr.dmas.virginia.gov/manuals/PD/chapterIV_pd.pdf	Yes (pursuant to 12VAC30-10-320)	Yes (pursuant to 12VAC30-10-320)	Yes	The MCO shall cover breast prostheses following medically necessary removal of a breast for any medical reason.

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Reconstructive Breast Surgery	12 VAC 30-50-140	Yes (pursuant to 12VAC30-10-320)	Yes (pursuant to 12VAC30-10-320)	Yes	MCO shall cover reconstructive breast surgery. Provide coverage for at least a 48-hour hospital stay following a radical or modified radical mastectomy and not less than 24 hours of inpatient care following a total mastectomy or a partial mastectomy with lymph node dissection for the treatment of breast cancer. Notwithstanding these requirements, the attending physician and the patient can determine that a shorter stay in the hospital is appropriate in accordance with Chapter 709 of 1998 Virginia Acts of Assembly, § 32.1-325 (A) of the Code of Virginia.
Regular Assisted Living Services Provided to Residents of Assisted Living Facilities	12 VAC 30-120-450 12 VAC 30-120 12 VAC 30-120-470 12 VAC 30-120-480 http://websrvr.dmas.virginia.gov/manuals/als/chapteriv_als.pdf	No	No	No	**The MCO is not required to cover this service.** When appropriate, the Department will reimburse the Assisted Living Facility as a carve-out payment.
Second Opinions	42CFR438.206	Yes (pursuant to 12VAC30-10-320)	Yes (pursuant to 12VAC30-10-320)	Yes	The MCO shall provide coverage for a second opinion when requested by the enrollee for the purpose of diagnosing an illness and/or confirming a treatment pattern of care. The MCO must provide for a second opinion from a qualified health care professional within the network, or arrange for the enrollee to obtain one outside the network, at no cost to the enrollee. The MCO may require an authorization to receive specialty care for an appropriate provider; however, cannot deny a second opinion request as a non-covered service.

Service	CFR, SPA or DMAS Manual Reference	A. Full Benefit Dual (Dual Eligible – QMB Plus)	B. Combination: Dual Eligible-QMB Plus with EDCD Waiver	C. EDCD Waiver (non Dual)	Notes
Telemedicine Services	http://websrvr.dmas.virginia.gov/manuals/phy/chapterIV_phy.pdf	Yes (pursuant to 12VAC30-10-320)	Yes (pursuant to 12VAC30-10-320)	Yes	The MCO shall provide coverage for telemedicine services at least to the extent covered by the Department. Telemedicine is defined as the real time or near real time two-way transfer of medical data and information using an interactive audio/video connection for the purposes of medical diagnosis and treatment. The Department recognizes physicians, nurse practitioners, nurse midwives, clinical nurse specialists-psychiatric, clinical psychologists, clinical social workers, licensed and professional counselors for medical telemedicine services and requires one of these types of providers at the main (hub) and satellite (spoke) sites for a telemedicine service to be reimbursed. Federal and State laws and regulations apply, including laws that prohibit debarred or suspended providers from participating in the Medicaid program. All telemedicine activities shall be compliant with HIPAA requirements.

Service	CFR, SPA or DMAS Manual Reference	A. Full Benefit Dual (Dual Eligible – QMB Plus)	B. Combination: Dual Eligible-QMB Plus with EDCD Waiver	C. EDCD Waiver (non Dual)	Notes
Temporary Detention Orders (TDOs) & Emergency Custody Orders (ECOs)	42 CFR 441.150 and Code of Virginia 16.1-335 et seq. Code of Virginia § 37.2-808 and the Appropriations Act of 2006 - 2008, Item 300, B http://websrvr.dmas.virginia.gov/manuals/HOS/appendixB_hos.pdf	Yes (pursuant to 12VAC30-10-320)	Yes (pursuant to 12VAC30-10-320)	Yes	The MCO shall provide, honor and be responsible for all requests for payment of services rendered as a result of a Temporary Detention Order (TDO) for Mental Health Services. The medical necessity of the TDO services is assumed by the Department to be established, and the MCO may not withhold or limit services specified in a TDO. Services such as an acute inpatient admission cannot be denied based on a diagnosis while the client is under TDO for Mental Health Services. For a minimum of twenty-four (24) hours with a maximum of 96 hours, a psychiatric evaluation for mental disorder or disease will occur. When an out-of-network provider provides TDO services, the MCO shall be responsible for reimbursement of these services. In the absence of a contract otherwise, all claims for TDO service shall be reimbursed at the applicable Medicaid fee-for-service rate in effect at the time the service was rendered. Temporary detention orders do not accrue toward the total number psychiatric visits. If it is determined by the judge, as the result of a hearing, that the client may be transferred without medically harmful consequences, the MCO may designate an appropriate in-network or out-of-network facility for the provision of care. The MCO will cover TDO in accordance with Medicaid timely filing requirements which are for one year from the date of the TDO. The MCO shall provide, honor and be responsible for payment of medically necessary screenings and assessments for persons who are under an emergency custody order.

Service	CFR, SPA or DMAS Manual Reference	A. Full Benefit Dual (Dual Eligible – QMB Plus)	B. Combination: Dual Eligible-QMB Plus with EDCD Waiver	C. EDCD Waiver (non Dual)	Notes
Transportation	12 VAC 30-50-530 12 VAC 30-50-300 http://websrvr.dmas.virginia.gov/manuals/TRA/chapter_4_tran.pdf	Yes (pursuant to 12VAC30-10-320)	Yes (pursuant to 12VAC30-10-320)	Yes	The MCO shall provide emergency transportation as well as non-emergency transportation to all Medicaid covered services. These modes include, but shall not be limited to, non-emergency air travel, non-emergency ground ambulance, stretcher vans, wheelchair vans, common user bus (intra-city and inter-city), volunteer/registered drivers, and taxicabs. The MCO shall cover air travel for critical needs. The MCO shall cover travel expenses determined to be necessary to secure medical examinations and treatment as set forth in § CFR 440.170(a). The MCO shall cover transportation to all Medicaid covered services, even if those Medicaid covered services are reimbursed by an out-of-network payer or are carved-out services. The MCO shall cover transportation to and from Medicaid covered community mental health and rehabilitation services.
Vision Services	12 VAC 30-50-210 http://websrvr.dmas.virginia.gov/manuals/vis/chapteriv_vis.pdf	Yes (pursuant to 12VAC30-10-320)	Yes (pursuant to 12VAC30-10-320)	Yes	The MCO shall cover Vision services which are defined as diagnostic examination and optometric treatment procedures and services by ophthalmologists, optometrists, and opticians. Routine refractions shall be allowed at least once in twenty-four (24) months. Routine eye examinations, for all enrollees, shall be allowed at least once every two (2) years. The MCO shall cover eyeglasses and contact lenses prescribed by a physician skilled in diseases of the eye or by an optometrist for enrollees up to age twenty-one (21), as medically necessary.

MENTAL HEALTH SERVICES					
Service	**State Plan Reference or Other Relevant Reference**	**A. Full Benefit Dual (Dual Eligible – QMB Plus)**	**B. Combination: Dual Eligible-QMB Plus with EDCD Waiver**	**C. EDCD Waiver (non Dual)**	**Notes**
Inpatient Mental Health Services					
Inpatient Mental Health Services Rendered in a Freestanding Psychiatric Hospital	12 VAC 30-50-230 12 VAC 30-50-250 http://websrvr.dmas.virginia.gov/manuals/CMHS/Chapter4_cmhrs.pdf	Yes (pursuant to 12VAC30-10-320)	Yes (pursuant to 12VAC30-10-320)	Yes	The MCO shall cover medically necessary inpatient psychiatric hospital stays for covered individuals over age sixty-four (64) or under age twenty-one (21). The MCO may authorize admission to a freestanding psychiatric hospital as an enhanced service to Medicaid enrollees. All inpatient psychiatric admissions for individuals under twenty-one (21) and over sixty-four (64) years of age to freestanding psychiatric facilities shall also be approved by the contractor using its own prior authorization criteria.
Inpatient Mental Health Services Rendered in a Psychiatric Unit of a General Acute Care Hospital	12 VAC 30-50-100	Yes (pursuant to 12VAC30-10-320)	Yes (pursuant to 12VAC30-10-320)	Yes	Medically necessary inpatient psychiatric care rendered in a psychiatric unit of a general acute care hospital shall be covered for all enrollees, regardless of age, within the limits of coverage prescribed in 12 VAC 30-50-105. All inpatient mental health admissions for individuals of any age to general acute care hospitals shall be approved by the MCO using its own prior authorization criteria.
Inpatient Mental Health Services Rendered in a State Psychiatric Hospital	12 VAC 30-50-230 12 VAC 30-50-250	No	No	No	**The MCO is not required to cover this service**. This service will be covered through the DMAS fee-for-service system. Notify DMAS of all enrollee admissions to state mental hospitals.
Temporary Detention Orders (TDOs)	42 CFR 441.150 and Code of Virginia 16.1-335 et seq. http://websrvr.dmas.virginia.gov/manuals/HOS/appendixB_hos.pdf	Yes (pursuant to 12VAC30-10-320)	Yes (pursuant to 12VAC30-10-320)	Yes	The MCO shall provide, honor, and be responsible for all requests for payment of services rendered as a result of a TDO for Mental Health Services.

MENTAL HEALTH SERVICES					
Service	**State Plan Reference or Other Relevant Reference**	**A. Full Benefit Dual (Dual Eligible – QMB Plus)**	**B. Combination: Dual Eligible-QMB Plus with EDCD Waiver**	**C. EDCD Waiver (non Dual)**	**Notes**
Treatment Foster Care (TFC) for children under age 21 years.	12VAC30-60-170 12VAC30-50-480 12VAC30-130-900 to 950 http://websrvr.dmas.virginia.gov/manuals/CMHS/Chapter4_cmhrs.pdf	No	No	No	**DMAS authorization into a TFC program will result in disenrollment of the recipient from VALTC.
Residential Treatment Facility Services (RTF) for children under age 21 years	12VAC30-130-850 to 890 http://websrvr.dmas.virginia.gov/manuals/CMHS/Chapter4_cmhrs.pdf	No	No	No	**DMAS authorization into a RTF program will result in disenrollment of the recipient from VALTC.
OUTPATIENT MENTAL HEALTH SERVICES ****The MCO is responsible to cover outpatient mental health services. The benefit maximum for adults **in the first year of treatment** shall not be less than 52 visits, and 26 visits per year following the first year of treatment. For children under age 21 the benefit maximum is based upon medical necessity. Medication management visits are not to be counted against the number of outpatient psychiatric visits.					
Psychiatric Diagnostic Exam	12VAC30-50-180 12VAC30-50-140	Yes (pursuant to 12VAC30-10-320)	Yes (pursuant to 12VAC30-10-320)	Yes	****
Individual Medical Psychotherapy	12VAC30-50-140 12VAC30-50-150 12VAC30-50-180 http://websrvr.dmas.virginia.gov/manuals/CMHS/Chapter4_cmhrs.pdf	Yes (pursuant to 12VAC30-10-320)	Yes (pursuant to 12VAC30-10-320)	Yes	****
Group Medical Psychotherapy	12VAC30-50-140 12VAC30-50-150 12VAC30-50-180 http://websrvr.dmas.virginia.gov/manuals/CMHS/Chapter4_cmhrs.pdf	Yes (pursuant to 12VAC30-10-320)	Yes (pursuant to 12VAC30-10-320)	Yes	****
Family Medical Psychotherapy	12VAC30-50-140 12VAC30-50-150 12VAC30-50-180 http://websrvr.dmas.virginia.gov/manuals/CMHS/Chapter4_cmhrs.pdf	Yes (pursuant to 12VAC30-10-320)	Yes (pursuant to 12VAC30-10-320)	Yes	****
Electroconvulsive Therapy	12VAC30-50-140 12VAC30-50-150 12VAC30-50-180	Yes (pursuant to 12VAC30-10-320)	Yes (pursuant to 12VAC30-10-320)	Yes	****

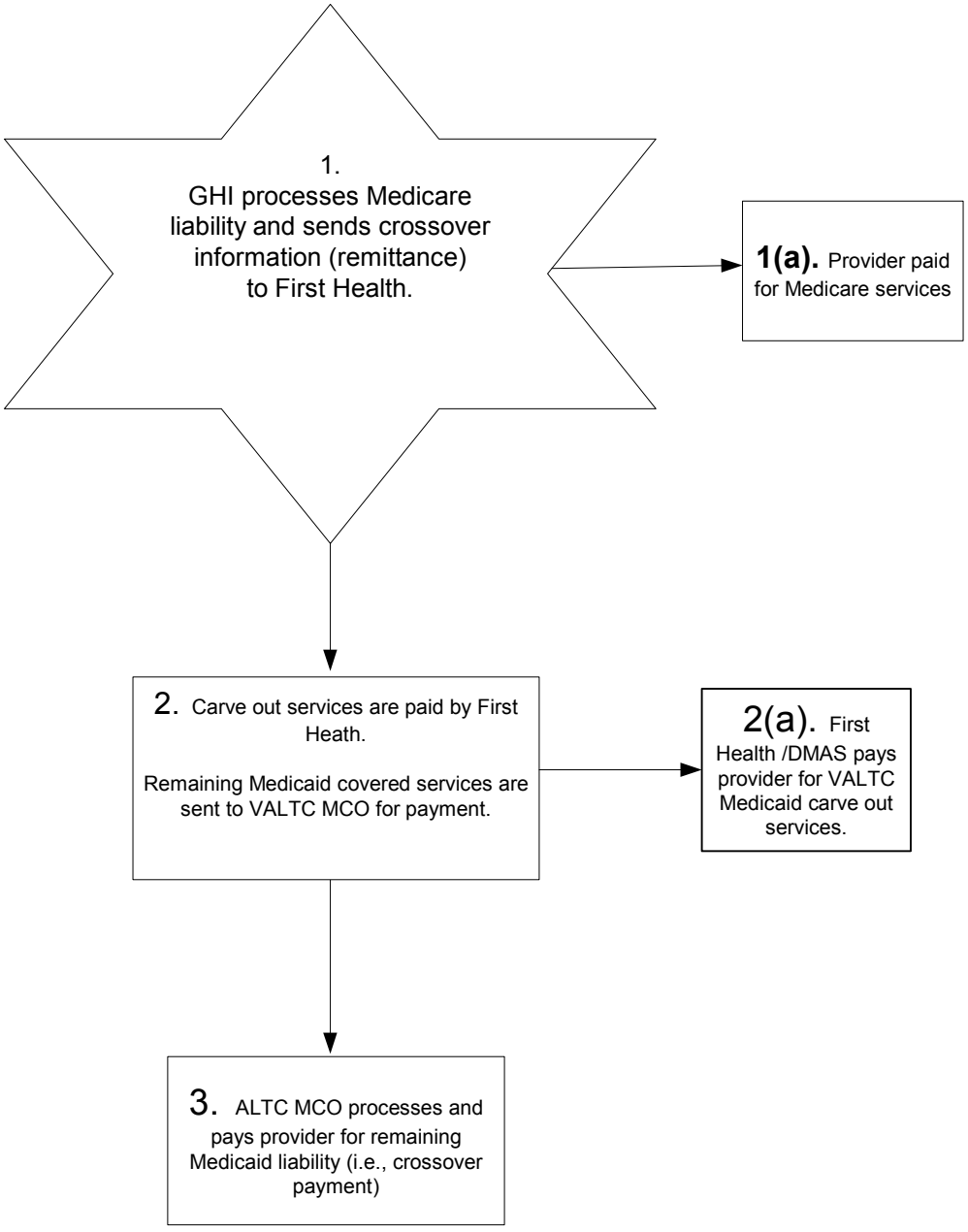
MENTAL HEALTH SERVICES					
Service	**State Plan Reference or Other Relevant Reference**	**A. Full Benefit Dual (Dual Eligible – QMB Plus)**	**B. Combination: Dual Eligible-QMB Plus with EDCD Waiver**	**C. EDCD Waiver (non Dual)**	**Notes**
Psychological/ Neuropsychological Testing	12VAC30-50-140 12VAC30-50-150 12VAC30-50-180	Yes (pursuant to 12VAC30-10-320)	Yes (pursuant to 12VAC30-10-320)	Yes	****
Pharmacological Management	12VAC30-50-140 12VAC30-50-150 12VAC30-50-180	Yes (pursuant to 12VAC30-10-320)	Yes (pursuant to 12VAC30-10-320)	Yes	****
COMMUNITY MENTAL HEALTH REHABILATATIVE SERVICES – STATE PLAN OPTION MENTAL HEALTH REHABILITATION SERVICES					
Community Mental Health Services	12VAC30-50-130 12VAC30-50-226 12VAC30-50-420 through 12VAC30-50-430 http://websrvr.dmas.virginia.gov/manuals/CMHS/Chapter4_cmhrs.pdf	No	No	No	**This service will be covered through a carve out.** The MCO must provide information and referrals as appropriate to assist recipients in accessing these services. The MCO shall cover transportation to and from SPO services and prescription drugs prescribed by the outpatient mental health provider.
Community Mental Retardation Services	12VAC30-50-440 http://websrvr.dmas.virginia.gov/manuals/MHMR/ChapIV_MR.pdf	No	No	No	**This service will be covered through a carve out.** The MCO must provide information and referrals as appropriate to assist recipients in accessing these services. The MCO shall cover transportation to and from SPO services and prescription drugs prescribed by the outpatient mental health provider.

SUBSTANCE ABUSE TREATMENT SERVICES					
Out-patient substance abuse treatment	12 VAC 30-50-141 12 VAC 30-50-151 12 VAC 30-50-181 http://websrvr.dmas.virginia.gov/manuals/CMHS/Chapter4_cmhrs.pdf	Yes (pursuant to 12VAC30-10-320)	Yes (pursuant to 12VAC30-10-320)	Yes	The MCO shall cover substance assessment and evaluation and outpatient services for substance abuse treatment for VALTC enrollees. Emergency counseling services, intensive outpatient services, day treatment, opioid treatment, and substance abuse case management services are **carved-out** of this contact and shall be covered by the Department. Transportation and pharmacy services necessary for the treatment of substance abuse, including for carved out services, shall be the responsibility of the MCO.
Residential Treatment for Pregnant Women	12VAC30-50-510 http://websrvr.dmas.virginia.gov/manuals/CMHS/Chapter4_cmhrs.pdf	No	No	No	**This service will be covered through a carve out.** The MCO must provide information and referral as appropriate to assist recipients in accessing this service. The MCO shall cover transportation to and from Community MH SPO services and prescription drugs prescribed by the mental health provider.
Day Treatment for Pregnant Women	12VAC30-50-510 http://websrvr.dmas.virginia.gov/manuals/CMHS/Chapter4_cmhrs.pdf	No	No	No	**This service will be covered through a carve out.** See comment directly above.

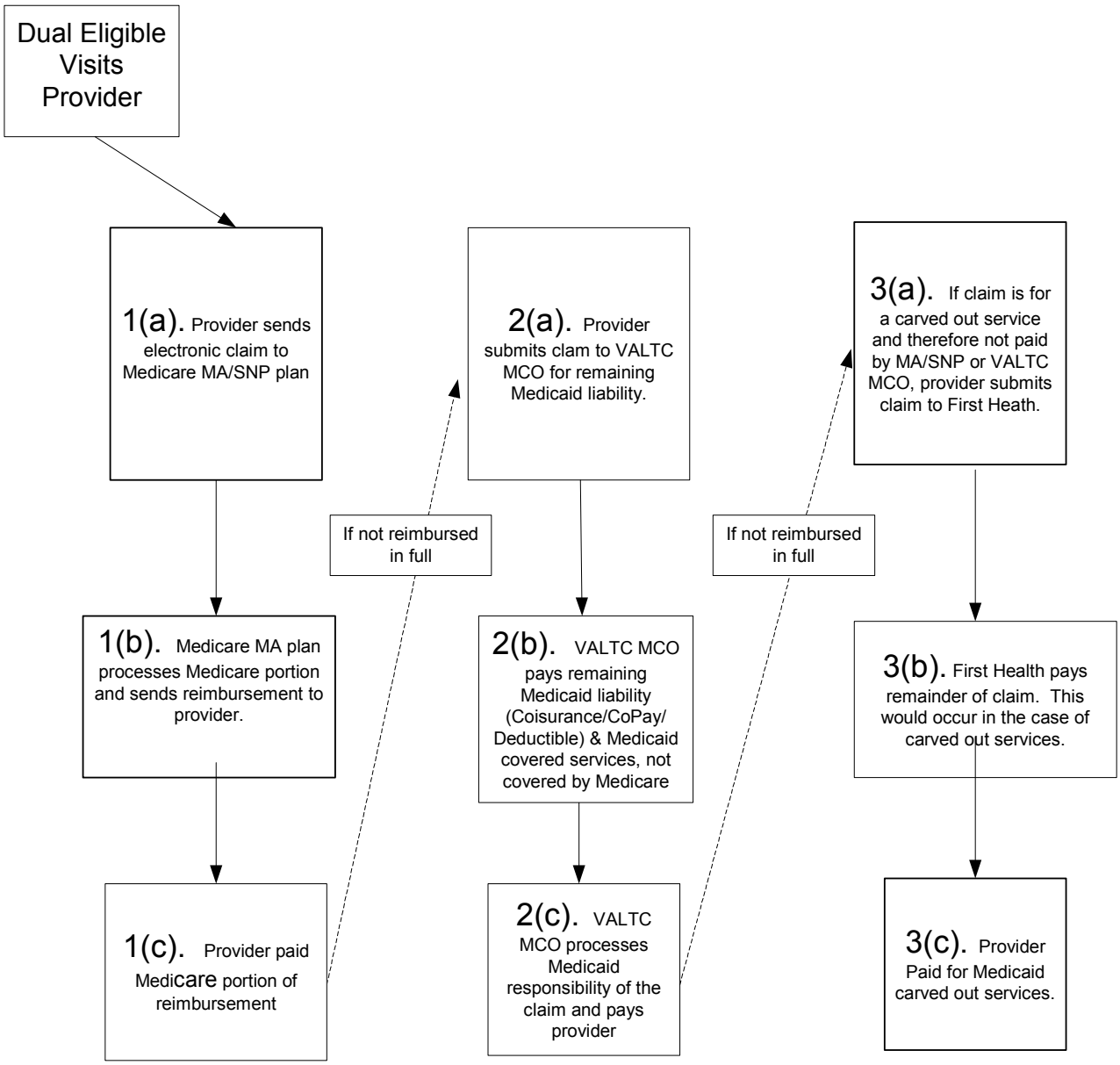
APPENDIX F Crossover Claims

VALTC Crossover Claims Process: Participant Not Enrolled in Medicare MCO

Revised March 12, 2008

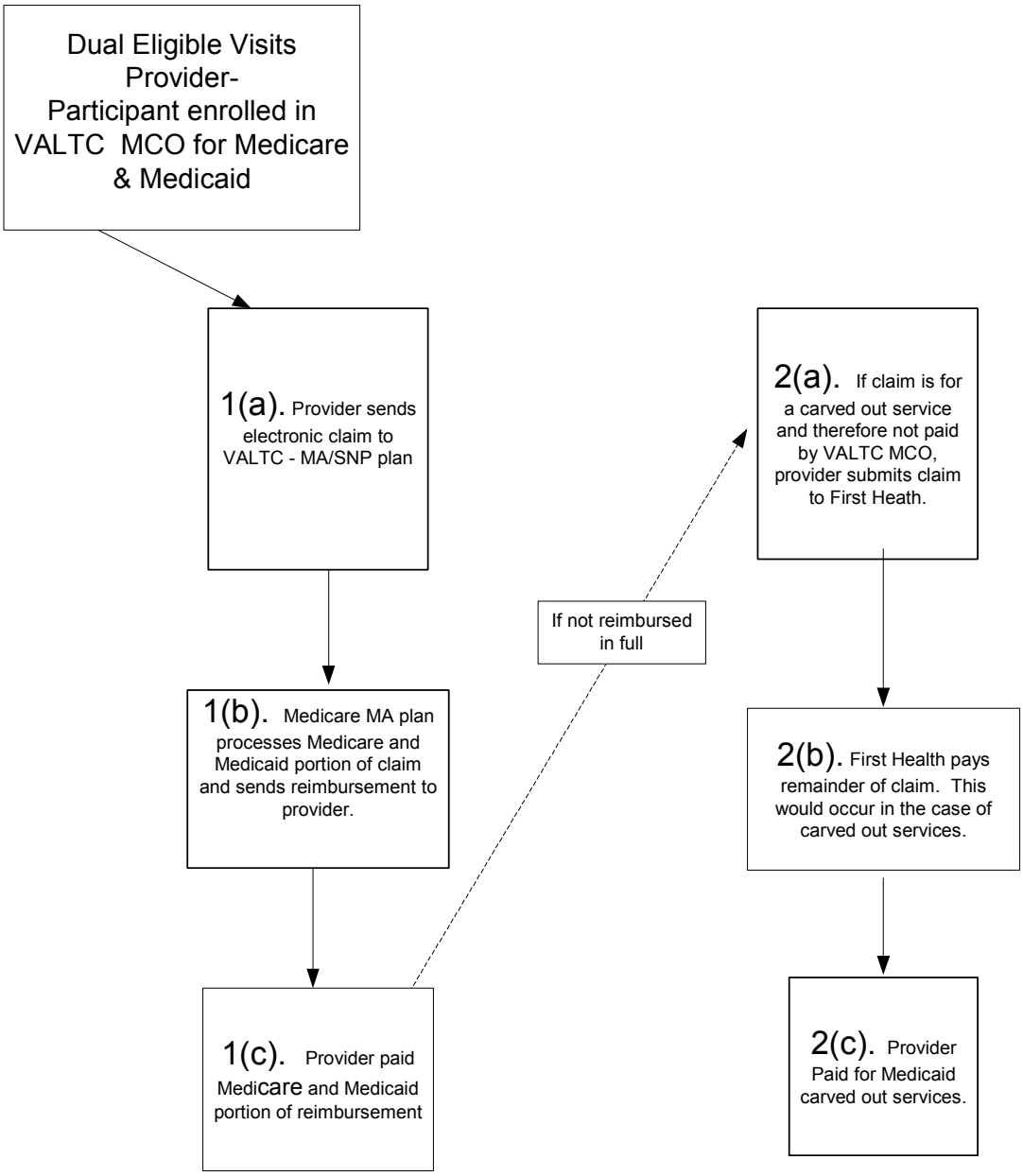


ALTC Crossover Claims Process: Participant Enrolled in **Non**-VALTC Medicare MCO Draft: January 25, 2008



VALTC Crossover Claims Process: Participant Enrolled in VALTC Medicare MCO for Medicare **and** Medicaid

Draft: January 25, 2008



APPENDIX G Consumer-Directed Fiscal/Employer Agent (F/EA) Services

A.1 Definitions

The following definitions are applicable to this appendix:

Alternative Formats - Material presented to allow people with disabilities access to the information. Examples would be written documents in Braille, recorded on tape or electronic versions.

Approved Policies And Procedures – Current policy and procedures approved by the F/EA through a defined approval process.

Attendant - The employee of a recipient receiving consumer-directed services who is providing services under an approved Plan of Care.

BCIS – Bureau of Citizenship and Immigration Services.

Consumer-Directed Attendant Application (DMAS 92) – The employment form completed by the attendant and recipient, and approved by the F/EA prior to payment for services.

DMAS-122 – Form completed by the recipient's local department of social services (LDSS) eligibility worker identifying a recipient's monthly patient pay amount. The LDSS worker sends this document to the Services Facilitator who sends a copy to the F/EA each year and when any changes are made to the patient pay amount.

VDSS – Virginia Department of Social Services.

Employment Eligibility Verification (BCIS I-9) Form – The BCIS requires all employers to verify the identity and work eligibility of U.S. citizens or aliens authorized to work in the United States.

Employment Packet - The combination of the Employment Application (DMAS-92), Employment Eligibility Verification (BCIS I-9), IRS Form W-4, state Form W-4 and IRS Notice 797.

Fiscal/Employer Agent (F/EA) - An organization operating under Section 3504 of the IRS Code and IRS Revenue Procedure 70-6 and Notice 2003-70 and has a separate Federal Employer Identification Number used for the sole purpose of filing federal employment tax forms and payments on behalf of program recipients it represents as Agent and who is bidding on this contract.

Representative - The person, a spouse, guardian, adult child, or parent of a minor child, who serves as the common-law employer for a recipient under 18 years of age or if the recipient is unable to self-direct their own care.

A.2 Technical Requirements

The MCO shall ensure that attendants who provide services to recipients receiving Medicaid consumer-directed services have completed the appropriate hiring paperwork including a criminal record check, meet requirements for employment in the United States, receive accurate, timely payment for services rendered and have State and Federal income taxes and employment taxes withheld, filed and paid in an accurate and timely manner. The MCO shall also ensure that the Medicaid recipient has an active authorization and is currently enrolled in the waiver or program that offers consumer-directed services. The MCO shall have current comprehensive F/EA policies and procedures manual, approve and maintain recipient enrollment packets, employment packets and process payroll. The MCO shall have internal controls documented and in place to monitor each of the mandatory tasks as listed in Section A.3.

A.3 Mandatory Tasks

A.3.1 A Current Comprehensive F/EA Policies and Procedures Manual for Review by DMAS

The MCO shall have a comprehensive F/EA policies and procedures manual including all policies, procedures and internal controls for all F/EA tasks as required in the Commonwealth of Virginia and the timeframes for implementing the policies, procedures and internal controls in Virginia related to this contract must be submitted to DMAS for review and approval at least 30 business days prior to the start of the contract. The MCO shall incorporate modifications required by DMAS within 10 business days of notification by DMAS. Any changes to the comprehensive F/EA policies and procedures manual must be approved to DMAS prior to implementation and distribution. The MCO shall not begin operations without an approved comprehensive F/EA policies and procedures manual.

The MCO's comprehensive F/EA policies and procedures manual must be available in electronic format and available to all MCO staff. The Manual must be incorporated into all training programs for new and existing MCO staff. The comprehensive F/EA policies and procedures manual must be reviewed and updated by the MCO at least annually and whenever changes in federal and state employment tax rules and/or operations change or as required by DMAS.

A.3.2 Obtaining Federal and State Approval to be a Serve as a Fiscal/Employer Agent (F/EA)

The MCO shall:

a. file an IRS Form SS-4 per IRS Instruction for Agents and obtain a separate Federal Employer Identification Number for the sole purpose of filing federal tax forms (including the IRS Forms 2678, 8821, 940, 941, W-2 and WS-3) and making tax payments for Medicaid recipients it represents as Agent. This FEIN shall be submitted with the bidder's proposal.
b. have documented, approved policies and procedures with stated timeframes for obtaining a federal employer identification number for each recipient it represents and for maintaining copies of the IRS FEIN notification letter (or the

number if F/EA did not get a letter from the IRS) and the filed Form SS-4, Request for FEIN in the recipient's file.

c. have documented, approved policies and procedures with stated timeframes for retiring recipients' FEINs when they are no longer employers.
d. have documented, approved policies and procedures with stated timeframes for preparing and submitting a signed IRS Form 2678: Appointment of Agent Form and Request for Approval Letter (multiple recipients may be listed on one letter) to the IRS for each recipient it represents. A copy of the IRS Form 2678 and Request for Approval Letter shall be maintained in each recipient's file.
e. receive written authorization from the IRS to be the Agent for each recipient it represents and have a copy of the written authorization in each recipient's file.
f. have documented, approved policies and procedures with stated timeframes for revoking the IRS Form 2678 with the recipient when the F/EA no longer represents the recipient and for maintaining the relevant documentation in each recipient's file.
g. have a system proven to be effective to file a signed IRS Form 8821, *Tax Information Authorization* with the IRS for each recipient it represents in order to communicate with the IRS on the recipient's behalf regarding FUTA issues and to maintain copies of the Form in each recipient's file. (It is recommended that all Federal Forms the F/EA manages be listed on the IRS Form 8821.) The MCO shall have a system proven to be effective to file IRS Form 8821 renewals for each applicable recipient at the appropriate time.
h. have documented, approved policies and procedures, and with stated timeframes for revoking the IRS Form 8821 when the Agent no longer represents the recipient and for maintaining the relevant documentation in each recipient's file.

A.3.3 Approving and Maintaining Recipient Enrollment Packets and Employment Packets and Processing Payroll

The MCO shall:

a. administer the payroll services throughout the designate region on behalf of all VALTC recipients who are authorized to participate in Medicaid consumer-directed services. The MCO shall manage employment documentation, payroll, and Federal and State tax responsibilities for the attendant of the common-law employer (recipient) hires directly.
b. notify the Department in writing monthly of any discrepancies in payments not validated by an approved authorization. The MCO shall have thirty calendar days to correct the discrepancy or reimburse the Department of any overpayments, if any and detail the credit on the next submitted voucher.
c. comply with requirements of 42 C.F.R. Part 447, including, but not limited to the requirements for timely payment to attendants, set forth in 42 C.F.R. § 447.45.
d. ensure payroll checks/direct deposits are paid within prompt-pay requirements.
e. The Department shall not be liable for over-draft charges or any other banking related charges assessed on the MCO's CD-Services payroll payment account. Any monetary charges, fees or penalties for claims not paid by the MCO within prompt-pay claims processing requirements or any other federal or state requirements, shall be borne by and be the sole obligation of the MCO.
f. The MCO shall prepare, sign, and mail paychecks or perform electronic direct deposit of funds, by the ninth calendar day following the end date of the pay period.
g. The MCO shall report any delays to checks that are not produced within the payroll cycle, the reason for the delay, and the corrective action taken.

A.3.4 Recipient Enrollment Packets

The MCO shall:

a. have and maintain a current recipient enrollment packet for each recipient that it represents that contains information about the MCO's F/EA services and operations (e.g., roles and responsibilities of the F/EA, recipient or representative), federal and state forms the recipient will complete, sign and return to the MCO to use F/EA services (e.g., IRS Form SS-4, 2678, 8821) timesheets, pay schedule and other applicable consent and contract forms.
b. have documented, approved policies and procedures with stated timeframes for producing, distributing, collecting, and processing the information contained in the recipient enrollment package within one business day of receiving a written request from the recipient. The MCO shall have internal controls documented and in place to monitor the production, distribution, collection, and processing of the information contained in the recipient enrollment packet.
c. shall be responsible for receiving the current DMAS-122 from the Department for each recipient before payment is made to attendant. This form documents the amount of the attendant's wages the recipient is obligated to pay each month.

A.3.5 Employment Packets

The MCO shall:

a. have and maintain a current employment packet for recipients' employees that contain all the

required forms, information, applications, and contracts and consent documents needed to enroll attendants as recipients' employees (e.g., employment application, IRS Form W-4, state Form W-4, IRS Notice 797).

b. have documented, approved policies and procedures with stated timeframes for producing and disseminating employment packets for recipients' employees containing all the required forms, information, applications, contracts and consent documents needed to enroll attendants as recipients' employees (e.g., employment application, IRS Form W-4, state version of a Form W-4, IRS Notice 797).
c. have documented, approved policies and procedures with stated timeframes for collecting, processing and maintaining the required human resources documentation from recipients and attendants in order to process payroll for attendants.
d. have a system in place, written policies and procedures and internal controls for verifying all attendants' self-reported social security numbers.
e. have documented, approved policies and procedures with stated timeframes for collecting, processing and maintaining IRS Forms W-4 for each attendant for whom it performs payroll.
f. have documented, approved policies and procedures with stated timeframes for collecting, processing and maintaining IRS Forms W-5 for each applicable attendant for whom it processes Federal Advanced Earned Income Credit (EIC) and have a copy of the form maintained in each attendant's file.
g. have a written policy and procedure for obtaining a completed and signed Form VA-4, when applicable, from each recipient it represents and for maintaining a copy in each recipient's file.
h. have documented, approved policies and procedures with stated timeframes for verify attendants' citizenship and alien status and for collecting and maintaining completed BCIS Form I-9 for each attendant it processes payroll for.
i. have written policies and procedures with stated timeframes according to DMAS policy for submitting the criminal record check upon request for each attendant, track the findings.
j. have current system in place to pay attendants in compliance with federal and state Department of Labor wage and hour rules.
k. have documented, approved policies and procedures with stated timeframes for reporting new hires per state requirements.
l. be responsible for receiving, verifying, processing and forwarding forms in the attendant employment packets to appropriate agency within 5 days of receipt. The MCO shall notify the recipient that the employment packet has been received and the status of the employment packet within one business day of receipt. If the packet is not complete then the MCO shall notify the recipient within three business days of receipt that their attendant's employment packet is incomplete. The MCO is responsible for receipt of these forms. If an employment packet is received prior to the recipient's authorization, the employment packet will be processed and kept until notification of authorization is received.
DMAS will approve all form revisions or development of new forms prior to implementation.

A.3.6 Authorizing Payments

Prior to authorizing payment to an attendant, the employment packet will be completed accurately and remain on file at the MCO.

Prior to authorizing payment to an attendant, the MCO shall verify that the recipient has a current authorization for consumer-directed services and is actively enrolled in the EDCD home-and-community-based waiver or EPSDT.

A.3.7 Time Sheets

It is the responsibility of the recipient to make sure that the bi-weekly time sheet is filled out completely, signed and sent to the MCO by the end of business, on the second business day following the end of the pay period.

The MCO shall:

a. receive time sheets that identify hours worked by the attendant for the recipient. The MCO shall maintain up-to-date authorization amounts to determine that the number of hours claimed for payment is authorized.
b. contact attendants, via email, mail or phone, who have timesheets containing errors that result in no payment processing action.
c. maintain a database and have documented, approved policies and procedures with stated timeframes for responding and tracking of occurrences of time sheets over billing and timesheets that cannot be paid due to late arrival, or missing or erroneous information.
d. be responsible for processing time sheets that are corrected and returned to the MCO with the next scheduled payroll batch run.
e. submit alternative methods for receiving the information needed to process payroll. These methods should be detailed in the response, to include hardware, software and the process for submission by the recipient/attendant.

A.3.8 Deductions

The MCO shall:

a. be responsible to pay the attendant in full for net wages earned, not to exceed the authorized number of hours approved.
b. ensure that if the recipient has a patient pay amount that is designated to consumer-directed

services, it will be deducted from the net wages of the attendant(s) on the pay period that includes the first day of each month. The total patient pay amount will be deducted from the attendant(s)' pay before any funds are used to pay for services. The patient pay amount and months of obligation are listed on the DMAS-122 and must be designated that the consumer-directed attendant is the collector of these funds.

c. send a payroll stub indicating the hours worked deduction and net earnings if the patient pay deduction generates a zero or negative net earnings.
d. have a system in place for deducting the total amount of patient pay prior to using any funds when multiple attendants are being paid for the recipient. There must be a hierarchy in place to determine the sequence of deductions from multiple attendants.
e. detail in the response to this contract the system that they will use to communicate to the recipient the amount of net wages the recipient is required to pay the attendant(s).
f. detail in the response to this contract the system that they will use to verify that the attendant(s) is being paid their earnings from the recipient.

A.3.9 Reconcile

The MCO shall:

a. establish an acceptable procedure for dealing with improperly cashed or issued checks, stop payment on checks, and for re-issuance of lost checks or improperly issued checks at no expense to DMAS. The MCO shall maintain a history of these transactions. DMAS shall not be liable for any overdrafts or charges that result in the processing of payroll.
b. reconcile payroll differences and unusual items provide a monthly history of all reconciliation..
c. send a copy of the monthly statement from the dedicated payroll bank account to the Department.
d. establish and communicate to DMAS a procedure for investigation and resolution of checks that have not been cashed. This procedure shall ensure due diligence is exercised in accordance with section 55-210.12 of the Code of Virginia. Any checks have not been cashed and that cannot be resolved within eighteen consecutive months of issue will be reportable under the Virginia Unclaimed Property Act (Section 55-210.1-55.210.30 of the Code of Virginia). The MCO shall submit to DMAS a list of checks reportable under the Virginia Unclaimed Property Act by September 1 of each year along with the funds associated with these checks. DMAS will prepare the annual filing of unclaimed property with the Commonwealth of Virginia.

A.3.10 Withholdings, Reporting and Statements

The MCO shall:

a. have documented, approved policies and procedures with stated timeframes for withholding and filing IRS Forms 941 (FICA – Medicare and Social Security taxes and federal income tax withholding) quarterly in the aggregate using the MCO's separate FEIN for all recipients it represents and maintain a copy of each IRS Form 941 filed in the MCO's files.
b. have documented, approved policies and procedures with stated timeframes for paying FICA and federal income tax withholding in the aggregate for all recipients it represents using the F/EA's separate FEIN and for maintaining relevant documentation in the MCO's files.
c. have documented, approved policies and procedures with stated timeframes for withholding and filing an IRS Form 940 to pay FUTA in the aggregate in an accurate and timely manner and maintains the relevant documentation in the MCO's files.
d. have documented, approved policies and procedures with stated timeframes for paying FUTA in the aggregate per IRS depositing rules and for maintaining the relevant documentation.
e. have documented, approved policies and procedures with stated timeframes for managing Federal Advanced EIC for each eligible attendant in an accurate and timely manner and maintaining the relevant documentation in the MCO's files.
f. have documented, approved policies and procedures with stated timeframes for obtaining state employer registration numbers for state income and unemployment tax withholding, filing and payment and maintaining the relevant documentation in the MCO's files.
g. have documented, approved policies and procedures with stated timeframes for withholding and filing state income taxes using State registration number for each recipient-employer per state requirements and for maintaining the relevant documentation in the MCO's files.
h. have documented, approved policies and procedures with stated timeframes for paying state income tax using recipient State registration number withholding for each attendant per state payment requirements and maintaining the relevant documentation in the MCO's files.
i. have documented, approved policies and procedures with stated timeframes for withholding and filing state unemployment insurance taxes individually for each recipient it represents using the recipient's FEIN and/or his or her state employer registration number per state requirements and maintaining the relevant documentation in the MCO's files.
j. have documented, approved policies and

procedures with stated timeframes for paying state unemployment taxes for each recipient-employer per state payment schedule and maintaining the relevant documentation in the MCO's files.

k. have documented, approved policies and procedures with stated timeframes for managing the application of all garnishments, levies and liens on attendants' payroll checks in an accurate and timely manner and for maintaining the relevant documentation in the MCO's files.
l. have documented, approved policies and procedures with stated timeframes to pay recipients' attendants within the time period required by the State Department of Labor (e.g., State "Payday" requirement).
m. have documented, approved policies and procedures with stated timeframes for processing direct deposit and for maintaining the relevant documents in the MCO's files.
n. have written policies and procedures with stated timeframes for completing employment verifications and Social Security earnings verification and other ancillary requests.
o. be knowledgeable and stay current of all Federal and State laws and regulations relevant to these responsibilities.

A.3.11 Implementing and Maintaining End Of Year Federal Tax Processes

The MCO shall:

a. have documented, approved policies and procedures with stated timeframes for identifying attendants that are due a FICA refund and their current mailing address and for refunding over collected FICA to applicable recipient-employers (or state or county government) in accordance with the December 18, 2000, IRS letter and employees and maintaining the relevant documentation in the MCO's files.
b. have a system in place, written policies and procedures and internal controls for submitting any reimbursement to attendants (e.g., FICA refunds) that are not successfully received by the applicable attendants to the State agency's responsible for implementing the Commonwealth of Virginia Abandoned Property Law.
c. have documented, approved policies and procedures with stated timeframes for preparing and distributing IRS Forms W-2 for recipients' attendants in accordance with IRS instructions for agents, electronic/magnetic filing when processing 250 or more IRS Forms W-2, and maintaining the relevant documentation in the MCO's files.
d. have documented, approved policies and procedures with stated timeframes for preparing and distributing IRS Forms W-3 in the aggregate for all recipients the F/EA represents when applicable per IRS instructions and maintaining the relevant documentation in the F/EA's files. When IRS Forms W-2 are filed electronically, MCO's do not have to file IRS Forms W-3.

A.3.12 Providing and Monitoring a Call Center

The MCO shall:

a. have an established Call Center to respond to all inquiries from recipients and attendants. Professional, prompt, and courteous customer service will be a high priority. All components of the Call Center that will need to be updated to comply with the contract will be approved by DMAS prior to implementation. The MCO must have a phone system that allows for the DMAS Contract Monitor to monitor phone calls historically and in real time. The Call Center must be located within the continental United States.
b. have dedicated service support staff shall be able to communicate with recipients whose primary language is not English. The recipient or attendant cannot be charged for translator services. Customer service representatives will be able to communicate effectively by voice and TTY with recipients who have disabilities.
c. have a current, live website that provides information about F/EA services that can be tailored to include Virginia Medicaid policies and procedures. The site will enable users to download employment packet forms, pay schedules, timesheets, tax forms and provide step-by-step directions for the completion of these forms. The website will be accessible to recipients with disabilities. There will be customer service/technical assistance telephone availability during business hours.
d. provide a current brochure, approved by DMAS, which will be tailored to specific Virginia Medicaid practices and distributed annually by the MCO and contain information about the payroll process for recipients. Written material will be written at the fourth grade literacy level and be available in Spanish, and alternative formats for individuals with disabilities.
e. conduct training sessions on how to educate the recipients regarding enrollment packets, employment packets and their individual roles and responsibilities related to payment for services.
f. demonstrate experience in providing training sessions to inform and educate recipients regarding enrollment packets, employment packets and their individual roles and responsibilities related to payment for services. All materials will be approved by DMAS prior to dissemination. The MCO shall submit an agenda for the training along with sample slides using Microsoft PowerPoint.
g. detail a rollout plan to convert the current

recipients and enroll future recipients. This plan shall be based on the assumption that there is currently only demographic and authorization information on each recipient.

h. detail a rollout plan to convert the current attendants and enroll future attendants. This plan shall be based on the assumption that there is currently only demographic information, hiring packet and I-9 forms on each attendant.

A.3.13 Developing, Implementing and Maintaining a Record Management Process

The MCO shall:

a. have an electronic system in place for establishing and maintaining current recipient, attendant and F/EA files in a secure and confidential manner as required by all applicable federal and state rules and regulations.

b. have documented, approved policies and procedures with stated timeframes documentation for establishing and maintaining electronic archived recipient, attendant and F/EA files in a secure and confidential manner and for the prescribed period of time as required by federal and state rules and regulations.

All time sheets, employment packets, attendant files and other files that DMAS provides to the MCO during transition and implementation of the contract shall be returned to DMAS when the contract ceases. These files shall be the sole property of DMAS. All reports, analyses, and/or publications developed under this contract will be the property of DMAS.

A.3.14 Staying Current With Federal and State Rules and Regulations Regarding Vendor F/EAs and Household Employers

The MCO shall:

a. stay current with all Federal and State rules and regulations regarding vendor F/EAs and household employers. The MCO must update and stay apprised of any and all changes in laws, forms and practices affecting the services provided under this contract.

b. have documented, approved policies and procedures with stated timeframes for reviewing and updating all IRS forms and instructions, notices and publications related to F/EA and preparing and filing federal taxes on behalf of household employers/recipients it represents at www.irs.gov.

c. have documented, approved policies and procedures with stated timeframes for reviewing and updating all state tax forms, instructions related to F/EA and preparing and filing state taxes on behalf of household employers/recipients it represents at the appropriate state web sites.

d. have written policies and procedures for reviewing and updating all applicable US Citizenship and Immigration Services (US CIS) rules, forms (i.e., US CIS Form I-9, Employment Eligibility Verification) and instructions.

e. have written policies and procedures for reviewing and updating all applicable federal Department of Labor rules, forms and instructions related to household employers and employees (Key web site: www.dol.gov).

f. have written policies and procedures for processing Commonwealth of Virginia New Hire Reports.

A.3.15 Preparing and Submitting the Required Reports to State Government and Individuals/Representatives

The MCO shall:

a. have a documented, approved policies and procedures with stated timeframes for preparing and submitting the required reports to the state government and individuals/representatives.

b. prepare and submit a bi-weekly accurate accounting of all payments made to attendants for services including a report of withholdings. This report will be provided in electronic and paper format and will be submitted to the Contract Monitor at DMAS.

c. provide the recipient or representative with quarterly and annual summaries of payments and deductions made on the recipient's behalf. These reports will be mailed to each recipient or representative and will include a letter asking the recipient or representative to identify any discrepancies with their personal records and to report those discrepancies to the MCO within ten business days. The MCO shall investigate each discrepancy to resolution and report to the Contract Monitor.

d. provide such additional reports, routine and/or ad hoc in relation to the contract requirements in a format as agreed upon by DMAS and the MCO. DMAS shall incur no expense in the generation of such reports. The F/EA shall make revisions in the data elements or format of the reports required in this contract upon request of DMAS and without additional charge to DMAS. DMAS shall provide written notice of such requested revisions of format changes in a notice of required report revisions. The MCO shall maintain a data gathering and storage system sufficient to meet the requirements of this contract.

DMAS reserves the right to change reporting requirements and request reasonable ad-hoc reports with sufficient notice. Reports will include, but not be limited to, Call Center statistics, employment packets, timesheets, payments, recipient data, attendant data, number and type of complaints and reports that track the payroll services

The MCO shall be obligated to assist and provide any documentation requested regarding any federal or

state audits, including, but not limited to, by the IRS, Health and Human Resources and the Office of the Inspector General as well as to update the Commonwealth on any changes in state or federal law affecting the withholding requirements under the contract.

A.3.16 Maintaining Confidentiality of Protected Health Information (PHI)

The MCO shall:

a. ensure that access to Medicaid and non-Medicaid Protected Health Information (PHI) will be limited to the MCO. The MCO shall take appropriate measures to safeguard all PHI and protect unauthorized disclosure of the Medicaid and non-Medicaid PHI in its possession. The MCO shall establish internal policies to ensure compliance with all Federal and State laws and regulations regarding confidentiality including, but not limited to, 42 CFR § 431, Subpart F, HIPAA and Virginia Code Section 2.1-377, et. seq. In no event will the MCO provide, allow, or otherwise permit, access to Medicaid and non-Medicaid PHI to anyone without the express written permission of the Director of DMAS. The MCO agrees that DMAS will neither grant access to nor provide PHI to the MCO until all elements of the DMAS Business Associate Contract have been satisfactorily executed between DMAS and the MCO. The MCO assumes all liabilities under both State and Federal law in the event that the PHI is disclosed in any manner. The MCO shall comply with all Federal regulations with regard to handling, processing, and providing safeguards as directed by DMAS in the use of PHI. This includes but is not limited to the Health Insurance Portability and Accountability Act (HIPAA) of 1996 final regulations. The MCO shall achieve and sustain compliance requirements as provided by the completed DMAS Business Associate Contract at no additional cost to DMAS.
b. as defined in section 160.103 of the Final HIPAA Privacy Rule, enter into this Business Associate Contract with DMAS to comply with the HIPAA Privacy regulation requirements that were effective April 14, 2003 and subsequent revisions.
c. not use PHI other than as expressly permitted, or as required by law.
d. ensure that any agents to whom it provides PHI received from DMAS agree in writing to the same restrictions, terms, and conditions relating to PHI that apply to the MCO.
e. report to DMAS immediately upon discovery, any use or disclosure of PHI made in violation of contract or any law. The MCO shall implement and maintain sanctions for any employee, or agent who violates the requirements of the Business Associate Contract or the HIPAA privacy regulations.
f. make an individual's PHI available to DMAS immediately upon an individual's request for such information as notified by DMAS.
g. make PHI available for amendment and correction and will incorporate any amendments or corrections to PHI immediately upon notification by DMAS.
h. submit a written Business Associate Data Security Plan within thirty-days of the execution of a Business Associate Contract. The Business Associate Data Security Plan will describe the manner in which the MCO will use DMAS' data and the procedures the MCO will employ to secure the data.
i. upon any requests for Medicaid information from any individual, entity, corporation, partnership, media or otherwise, notify DMAS within one business day. The MCO shall ensure that there will be no disclosure of the data except through DMAS. DMAS will treat such requests in accordance with DMAS policies.
j. in cases where the information requested by outside sources is releasable under the Freedom of Information Act (FOIA), as determined by DMAS, agree to copy and invoice such documents at the MCO's expense. All FOIA requests received by the MCO shall be reported to DMAS within one business day. FOIA information will be released by DMAS.
k. provide any information requested by DMAS within one business day of the request. DMAS is willing to provide a waiver of this requirement based on reasonable explanation and approval from DMAS.

A.3.17 Developing, Implementing and Maintaining Automation of Systems

The MCO shall:

a. have the ability to receive and process time sheets and utilizing software that will directly import data into a database system. This automation will ensure the timeliness and accuracy of data entry and storage. These systems will be capable of allowing for future growth in service volume.
b. describe the current operational computer database that meets the needs of the Consumer-Directed Payroll Services as determined by DMAS. DMAS will provide an export file of current recipient, attendant, and payroll tables. This file will be a Microsoft Excel Spreadsheet with demographic information. It is the responsibility of the MCO to ensure its current database accepts the format of the DMAS export file. Although the MCO will house this database at their facility, DMAS will have access to the database and will own the information.
c. be required to submit their current Disaster Recovery Plan for restoring software and data

files and hardware backup if management information systems are disabled so that continuation of payroll and invoice payment systems remain intact. The MCO shall have a duplicated server ready to take over at any time due to loss of electricity or breakdown.

d. be responsible for all programming functions and costs associated with the design, maintenance or enhancements of the database.
e. demonstrate experience in data accumulation and in writing reports that are well organized, clear, concise and readable by laypersons.

A.3.18 Creating and Distributing a Recipient Satisfaction Survey

Annual Recipient Satisfaction Survey: The F/EA will conduct an annual consumer-directed services recipient satisfaction survey. The survey will use sampling strategies and questions that are approved by DMAS. The survey must be conducted with a reliable sample size that is at least ten percent of enrolled recipients. The F/EA must provide the results of the recipient satisfaction survey in a comprehensive report and all completed surveys within 30 days of completion of the survey.

The F/EA will describe in detail its approach to and experience with recipient satisfaction surveys. The F/EA will detail its plans for surveying specific populations such as recipients with disabilities, family members of recipients, recipients that have primary language other than English and recipients' ability to respond to mail survey.

A.3.19 Resolving Complaints and Maintaining A Tracking System

The MCO shall:

a. be responsible for receiving, responding and tracking all complaints about F/EA services from any source under this contract.
b. attempt to respond verbally to the complainant within one business day of receipt and respond to written complaints in writing within five business days.
c. have documented, approved policies and procedures with stated timeframes for handling all complaints, including documentation requirements.
d. maintain an electronic log of all complaints, with documentation of the complaint and action(s) taken to resolve the complaint. The MCO shall compile a summary report and analyze complaints received on a monthly basis to determine quality of services to recipients and any corrective action. The MCO shall analyze the complaint data for quality improvement. The MCO shall send a summary report to DMAS on a monthly basis of complaints received and their resolution in accordance with the specifications and format approved by DMAS.

A.3.20 Liquidated Damages

The Department may impose liquidated damages upon reasonable determination that the MCO fails to comply with its obligations under the contract.

When DMAS identifies after notification of corrective action, that the specified processing timeframes are not being met and a backlog has occurred as a result, liquidated damages will be assessed in the amount of up to $1,000 per day for each and every calendar day of delay beyond the time specified; except that if the delivery be delayed by any act, negligence, or default on the part of the Commonwealth, public enemy, war, embargo, fire, or explosion not caused by the negligence or intentional act of the MCO or his supplier(s), or by riot, riot, sabotage, or labor trouble that results from a cause or causes entirely beyond the control or fault of the MCO or his supplier(s), a reasonable extension of time as the procuring public body deems appropriate may be granted. Upon receipt of a written request and justification for any extension from the MCO, the purchasing office may extend the time for performance of the Contract or delivery of goods herein specified, at the purchasing office's sole discretion, for good cause shown.

The MCO shall be solely responsible for all fines and/or penalties assessed by agencies (i.e. IRS, etc.) based on the timeliness or accuracy of the MCO's duties.

A.3.21 Subcontracting

If the MCO that is awarded the contract will or intends to use subcontractors for the F/EA functions, the MCO must have a current Comprehensive Policies and Procedures Manual that fully explains its policies and procedures for all tasks that will be performed by any sub-contractor. The MCO shall have internal controls documented to monitor the performance of all tasks performed by a subcontractor. The MCO shall provide in the Covered Services Proposal a detailed explanation of why a sub-contractor would be used to perform any of the responsibilities of the contract.

The foregoing notwithstanding, no portion of the F/EA duties can be subcontracted to a reporting agent.

B. DMAS' RESPONSIBILITIES

a. Provide all Medicaid and Waiver policy interpretations.
b. Determine whether applicants for Medicaid Waiver Programs meet all eligibility requirements. Eligibility data for all waivers will be entered in the VAMMIS system. DMAS will notify the MCO of the recipient's name, Medicaid identification number, the date when authorization of service(s) begins/ends and the number of hours the recipient is authorized to receive.
c. Establish an hourly rate to be paid to attendants

and provide that information to the MCO. Notify MCO of rate increases and their effective date.

d. Provide a DMAS contact person for ongoing project management and contract performance monitoring.

e. Review and approve any written communications to recipients, attendants, providers and others prior to release.

Department of Medical Assistance Services (DMAS)
Consumer-directed Services Attendant Application

Employer Information

Recipient's Last Name		**Recipient's First Name**	
Address		City	
State	Zip	Medicaid Number	
Telephone Number	( )	Social Security Number	

Employee Information

Attendant's Last Name		**Attendant's First Name**	
Address			
City		State / Zip	
Social Security Number		Telephone Number	( )
Alternate Telephone	( )	Relationship to Employer*	

Services Facilitator Information

Agency Name		**Facilitator's Name**	
Address			
City		State / Zip	
Telephone Number	( )	Alternate Telephone	( )

8.2. *Signature Authentication*

Individuals selecting consumer-directed services are required to sign documentation confirming that services were delivered as stated. Individuals will provide their original signature so that all future signatures can be verified as authentic.

1) If the recipient is directing their own care and will be signing forms then the signature at end of this form will be used to verify future signatures.

2) If the recipient makes a mark or has an illegible signature then someone other than the attendant will witness the form and this section will be completed.

Recipient's Mark		**Date**	
Witness' Last Name		**Witness' First Name**	
Signature		**Date**	

3) If a person other than the recipient will be the employee of record then they will complete and sign this form. Whenever signing the authorized signer will sign their name and then print the recipient's name after their signature.

Authorized signer's Last Name		**Authorized signer's First Name**			
Signature	Signing for:			Date	
Authorized signer's Last Name		**Authorized signer's First Name**			
Signature	**Signing for:**			Date	

Permission for DMAS to act as Fiscal/Employer Agent for Employer

The Internal Revenue Service ("IRS") has determined that you and your Personal Assistant/Companion have a common-law employer-employee relationship, which means that you are the common-law employer of your Personal Assistant/Companion.

Social Security laws require that all employers pay FICA (Federal Insurance Contributions Act) tax to the federal government to allow the employee to have Social Security benefits. In addition, employers will pay federal and state unemployment taxes for their employees. As such, FICA and federal and state unemployment taxes will now be paid for your attendant.

The Department of Medical Assistance Services will make these tax payments on your behalf to the federal government once you authorize the agency to act as your Fiscal/Employer Agent. These tax payments will be made without cost to you.

Please sign and date the statement printed below so that these tax payments can begin. The Department of Medical Assistance Services will keep this statement on file. Without your signed authorization, services cannot be provided, and payment of these taxes would be your responsibility.

Authorization

I authorize the Department of Medical Assistance Services to act as my Fiscal/Employer Agent in withholding FICA taxes from the wages being paid on my behalf to the person who provides care to me in my home. I also understand that the Department of Medical Assistance Services will collect and pay the necessary Social Security taxes; pay federal and state unemployment taxes as needed; and issue W-2 forms as required for payment made to my service provider on my behalf.

1. Employee Contract

Parties to Contract

This employment contract is made this ____ day of _____, 20 ____, by and between _____, hereinafter called "Personal Attendant," and _____, hereinafter called "Employer." The purpose of this contract is to establish the responsibilities of the parties to each other. The Personal Attendant is an employee at will.

Compensation

The Personal Attendant will be compensated for his or her services at the hourly rate of $_____. The Personal Attendant will not be paid for providing services until the Fiscal/Employer Agent receives both a notice of approved authorization for services and a completed, approved attendant application.

Duration of Contract

This contract will be effective when both parties sign it. Either party may terminate this Contract and the employment contemplated herein at any time and without liability for doing so, by giving the other party hereto at least 5 (five) days prior notice. Notice may be provided either orally or in writing.

Modification of Contract

The only terms that may be modified are the scheduling terms. Modification of this contract will be in writing.

Scheduling

If the Personal Attendant is unable to work a scheduled time, the Personal Attendant will provide at least _____hours advance notice to the Employer, in order for the Employer to find an alternate. A change in time by the Employer or Personal Attendant will be scheduled at least _____ hours in advance. In case of emergency, the Personal Attendant will notify the Employer or another designated person. Such person will be designated in advance, in writing. If a Personal Attendant is knowingly going to be late, he or she will notify the Employer by telephone.

Personal Attendant Qualifications

The Personal Attendant attests that he or she meets the minimum qualifications.

1) Personal Attendant is 18 years of age or older;
2) Personal Attendant has the required skills to perform services as specified in the Employer's service plan;
3) Personal Attendant possesses basic math, reading, and writing skills in English;
4) Personal Attendant possesses a valid Social Security number;
5) The Personal Attendant is a citizen of the United States, or is otherwise eligible to work in this country as verified on the Employment Eligibility Verification Form.
6) Personal Attendant is willing to submit to a criminal record check upon employment; Employer agrees to select or employ Personal Attendant **on an interim basis pending completion of a criminal history record check, for those crimes as specified in 12 VAC 30-90-180.** The Employer has discussed with the Personal Attendant and reserves the right to dismiss the Personal Attendant based on the results of the criminal history record check. and
7) Personal Attendant can demonstrate the capability to perform health maintenance activities required by the Employer or specified in the Employer's service plan, or be willing to receive training in performance of the specified health maintenance activities.
8) For EDCD Waiver, Personal Attendant is not the spouse or parent or stepparent if recipient is a minor. For IFDDS and MR Waiver, Personal Attendant is not the parent, if recipient is a minor, spouse or legally responsible relative of the recipient. I understand that I may not be paid for services furnished if I am another family member/caregiver living under the same roof unless there is objective written documentation attached to this application as to why there are no other providers available to provide the care and that this situation will be approved by the recipient's Service Facilitator and the Fiscal/employer agent.
9) The Personal Attendant will not be paid while the recipient is in the hospital or nursing facility. The Personal Attendant will not be paid for time he or she does not work.
10) The Personal Attendant is responsible for filing and paying Federal and State income taxes. I understand that Social Security and Medicare payments (FICA) will be withheld from my check and forwarded to Social Security on behalf of my common-law employer.

Personal Attendant Duties

Duties of the Personal Attendant include, but are not limited to, the following:

1) Personal Attendant agrees to assist the Employer by providing the services and performing the activities specified in Employer's service plan;

2) Personal Attendant agrees to protect the health and welfare of the Employer by providing authorized services in accordance with the policies and standards of the EDCD/IFDDS/ MR/AIDS Waiver Programs, including the Minimum Qualifications for Employment as a Personal Attendant;

3) Personal Attendant agrees to provide Personal Attendant/Respite/ Companion Services as specified in the Employer's service plan on a schedule mutually agreed upon between the Employer and the Personal Attendant. Occasional variations in the Personal Attendant tasks and in the schedule may occur, based on mutual contract of the parties;

4) In the event of illness, emergency, or incident preventing Personal Attendant from providing scheduled service to the Employer, the Personal Attendant agrees to notify the Employer as soon as possible so that the Employer can obtain assistance from someone else;

5) Personal Attendant agrees to participate in training in providing services, including training in performing any allowable health activities, as required by the Employer or as specified in the Employer's service plan;

6) Personal Attendant agrees to confidentially maintain all information regarding the Employer and to respect the Employer's privacy;

7) Personal Attendant agrees to pay all required federal, state, and/or local wage and/or income taxes levied against the Personal Attendant's wages. The Personal Attendant agrees to cooperate with the Employer and the Employer's Fiscal/Employer Agent in providing information needed to comply with all income and unemployment taxation laws and regulations;

8) Personal Attendant understands that this contract does not guarantee employment or payment of wages for any time period;

9) Personal Attendant understands that the Personal Attendant is employed by the Employer and not by the Services Facilitator Provider, the Employer's Fiscal/employer agent, or the Commonwealth of Virginia;

10) Employer's property is not to be used for the Personal Attendant's personal use, unless mutually agreed upon by both parties prior to use of property. All private matters discussed during working times will be kept confidential; and

11) Personal Attendants are to be punctual, neatly dressed, and respectful of all family members. All instructions as to care will be carried out carefully. The Employer's telephone may be used only with prior permission on each occurrence.

Employer Responsibilities

1) Employer agrees to select or employ Personal Attendant **on an interim basis pending completion of a criminal history record check, for those crimes as specified in 12 VAC 30-90-180.** The Employer has discussed with the Personal Attendant and reserves the right to dismiss the Personal Attendant based on the results of the criminal history record check.

2) Employer agrees to orient, train, and direct the Personal Attendant in providing the Personal Attendant services that are described and authorized by the Employer's service plan or that are requested by the Employer.

3) Employer agrees to establish a mutually agreeable schedule for the Personal Attendant' services either orally or in writing.

4) Employer agrees to provide adequate notice of changes in the Personal Attendant's work schedule in the event of unforeseen circumstances or emergencies, but such notice cannot be guaranteed.

5) In consideration of Personal Attendant's satisfactory job performance, the Employer agrees to authorize completed Personal Attendant time sheets and to pay the Personal Attendant net wages on a regular and timely basis according to a predetermined payroll schedule. Net wages will include gross earnings calculated according to the Personal Attendant's pay rate minus payroll deductions for employee's share of FICA and other deductions as appropriate.

Mutual Responsibilities

The parties agree to follow the policies and procedures of the Employer's Services facilitator, of the Services facilitator's Agency's designees, and of the EDCD/IFDDS/MR/AIDS Waiver Programs. The Personal Attendant and Employer agree to hold harmless, release, and forever discharge the Department of Medical Assistance Services and the Services Facilitator from any claims and/or damages that might arise out of any action or omissions by the Personal Attendant or the Employer.

Employer's Signature (state signing for if not the recipient)	Date
(If Guardian) Relationship to Employer	Date
Personal Attendant Signature	Date
Services Facilitator Signature	Date

You will attach a completed U.S. Department of Justice, Employment Eligibility Verification (I-9) form for the employment packet to be complete.

Report Outline

All of these reports should be available in detail including totals by locality. All information shall be able to be reported by waiver, recipient, and attendant.

1) **Bi-weekly Recipient Services and Attendant Payment Reports**
   - Total number of payroll checks issued in each batch run
   - Total number of unduplicated attendants paid in each batch run
   - Total number of unduplicated recipients receiving services in each batch run
   - Total hours of service paid in each batch run: by waiver, service within the waiver and payroll period
   - Total amount of payments made to attendants in each batch run: by waiver, service within the waiver and payroll period
   - Total number of unduplicated attendants paid by waiver and services within the waiver in each batch run
   - Total number of unduplicated recipients receiving services by waiver and services within the waiver in each batch run
   - Average payment per service by waiver and services within the waiver
   - Total number of employment packets received each week
   - Number of employment packets approved each week
   - Total number of attendants approved to provide services
   - Total number of recipients approved to receive services
   - Number of new attendants approved each week
   - Number of new recipients authorized each week by waiver and services within the waiver
   - Number of attendants made inactive each week and reason they became inactive
   - Number of recipients made inactive each week and reason they became inactive
   - Average number of attendants per recipient
   - Number of attendants, recipients, and services facilitators receiving technical assistance and type of assistance provided
   - Number of employment packets returned for completion and the corrections needed
   - Reconciliation of improperly cashed or issued checks, stop payment on checks and report re-issuance of lost checks or improperly issued checks.
   - Reconciliation of incorrect social security numbers for attendants

2) **Quarterly and Annual Recipient Services and Attendant Payment Reports**
   - Number of unduplicated recipients receiving services during period (quarter or annual) by waiver and services within the waiver
   - Number of hours of service during period (quarter or annual) by waiver and services within the waiver
   - Hours of service per recipient during period (quarter or annual) by waiver and services within the waiver
   - Total number of unduplicated attendants during period (quarter or annual) by waiver and services within the waiver
   - Average number of attendants per recipient during period (quarter or annual) by waiver and services within the waiver
   - Number of new attendants approved during period (quarter or annual) by waiver
   - Total number of criminal record checks performed on new attendants during period (quarter or annual) by waiver.
   - Total number of criminal record checks that resulted in termination of the attendant per waiver regulation during period (quarter or annual) by waiver
   - Total number of termination notifications submitted by recipients per waiver
   - Number of attendants made inactive during period (quarter or annual)
   - Number of new recipients authorized during period (quarter or annual) by waiver and services within the waiver

- Number of recipients made inactive during period (quarter or annual) by waiver and services within the waiver
- Total payments during period (quarter or annual) by waiver and services within the waiver
- Payments per recipient during period (quarter or annual) by waiver and services within the waiver

3) Monthly Complaint Report & Log

- Compilation of the complaints by source and type
- Compilation and details of the nature and number of complaints resolved

4) Annual Recipient Satisfaction Survey

5) Quarterly Quality Management Activity Report

6) Annual Report

i) System description
ii) Contracted services
iii) Major problems and how addressed
iv) Future Plans
v) Suggestions to DMAS
vi) Statistical summary of information provided in Section 4

APPENDIX H MCO Active DMAS Provider File Data Requirements

FIELD NAME	DATA VARIATIONS / EXAMPLES
MCO Code*	Your number assigned by DMAS
Provider Type*	Examples are: Ancillary, CSB (Community Service Board), Early Intervention, Health Department, Hospital, Independent Lab, OB/GYN, Optical, PCP, PCP – Pediatric, Pharmacy, Psychiatric
Provider Specialty*	Examples are: Anesthesiologist, Cardiologist, DME, Hospital, Infectious Disease, Internal Medicine, OB/GYN, Pediatrician, Transportation, etc.
NPI/API	9999999999
PCP Status*	Y or N
Provider Last Name*	Smith or ABC Hospital
Provider First Name	Robert or blank if facility name listed above
Address line 1*	123 Any Road
Address line 2	Suite 900
City*	Anywhere
State*	VA
Zip code*	99999
Phone area code	999
Phone number	999-9999
Phone extension	9999
24 Hour Access*	Yes or No
Other Language Spoken 1	Examples are: French, German, Italian, Russian, Spanish, etc.
Other Language Spoken 2	Examples are: French, German, Italian, Russian, Spanish, etc.
PCP maximum panel size**	2,500
PCP assigned panel size**	150
PCP limitations/restrictions**	Examples are: Children Age 5-18, No new patients, etc.

* This field must be included for every record in the file.
** This field must be included for every PCP record in the file.

Notes:
The quarterly report to DMAS must be reported in an excel spreadsheet and must be provided electronically to the DMAS VALTC Transition Coordinator.

The complete provider file; i.e., all PCPs, specialists, and subcontractor networks (this includes transportation, psychiatric, optical, and/or pharmacy, etc.) must be submitted. The subcontractor network must include the complete listing of vendors with whom the subcontractor contracts to provide services to VALTC program recipients.

The entire network should be in one file, formatted as above; not separate files or separate worksheets within one file. For providers with multiple office locations, each office location must be listed on a different line.

Minimum Required Fields for Provider File Submission for the Enrollment Broker - The format of the enrollment broker provider file is not mandated. The following fields are required fields for any file submitted, however, this file layout may be amended to include LTC providers.

Number	Data Element	Type	Size	Start	Stop
1	MCO Code*	numeric	10	1	10
2	Action Ind* (A=Active, D=Delete)	alpha	1	11	11
3	Clinic/PCP Ind* (P=PCP, C=Clinic)	alpha	1	12	12
4	Provider Number **	alpha	15	13	27
5	Program Code* (M2=Medallion II)	alpha	2	28	29
6	Provider Last Name*	alpha	30	30	59
7	Provider First Name*	alpha	30	60	89
8	Address Line 1	alpha	30	90	119
9	Address Line 2	alpha	30	120	149
10	City	alpha	30	150	179
11	Zip Code	numeric	9	180	188
12	Phone Area Code	numeric	3	189	191
13	Phone Number	numeric	7	192	198
14	Phone Extension	numeric	4	199	202
15	Office Hours	alpha	25	203	227
16	Specialty Code (see below)	alpha	1	228	228
17	Language 1 (see below)	alpha	2	229	230
18	Language 2	alpha	2	231	232
19	Language 3	alpha	2	233	234
20	Language 4	alpha	2	235	236
21	Language 5	alpha	2	237	238

* This filed must be included for every record in the file

** The Provider Number field must be unique per provider and office location

Specialty Codes

C=Clinic
F=Family
G=General
I=Internist
O=OB/GYN
P=Pediatrics
X=Other

Languages

SP=Spanish
GR=German
FR=French
IT=Italian
RS=Russian

APPENDIX I CMS Assurances

Level of Care (LOC)

1. An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.
2. The LOC of enrolled participants are reevaluated at least annually or as specified in the approved waiver.
3. The processes and instruments described in the approved waiver are applied to determine LOC.
4. The state monitors LOC decisions and takes action to address inappropriate LOC determinations.

Service Plan

5. Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.
6. The state monitors service plan development in accordance with its policies and procedures and takes appropriate action when it identifies inadequacies in service plan development.
7. Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.
8. Services are delivered in accordance with the service plan, including in the type, scope, amount, duration, and frequency specified in the service plan.
9. Participants are afforded choice:
    - Between waiver services and institutional care; and
    - Between/among waiver services and providers.

Qualified Providers

10. The state verifies that providers meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.
11. The state verifies on a periodic basis that providers continue to meet required licensure and/or certification standards and/or adhere to other state standards.
12. The state monitors non-licensed/non-certified providers to assure adherence to waiver requirements.
13. The state identifies and remediates situations where providers do not meet requirements.
14. The state implements its policies and procedures for verifying that provider training has been conducted in accordance with state requirements and the approved waiver.

Health and Welfare

15. There is continuous monitoring of the health and welfare of waiver participants and remediation actions are initiated when appropriate.
16. The state, on an ongoing basis, identifies and addresses and seeks to prevent the occurrence of abuse, neglect and exploitation.

Administrative Authority

17. The Medicaid agency retains ultimate authority and responsibility for the operation of the waiver by exercising oversight over the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

Financial Accountability

18. Claims for Federal financial participation in the costs of waiver services are based on state payments for waiver services that have been rendered to waiver participants, authorized in the service plan, and properly billed by qualified waiver providers in accordance with the approved waiver.

APPENDIX J Network Provider Contract

A. Right of Department to Approve, Modify or Disapprove Network Provider Contracts

The Department may approve, modify and approve, or deny network provider contracts under this Contract at its sole discretion. The Department may, at its sole discretion impose such conditions or limitations on its approval of a contract as it deems appropriate. The Department may consider such factors as it deems appropriate to protect the interests of the Commonwealth and recipients, including but not limited to the proposed provider's past performance. The MCO shall submit any new network provider contract at least thirty (30) days prior to the effective date for review, and annually thereafter. Revisions to any contracts must be submitted at least thirty (30) days prior to the effective date of use. The MCO shall have no greater than one hundred and twenty (120) days to implement a change that requires the MCO to find a new network provider, and sixty (60) days to implement any other change required by the Department, except that this requirement may be shortened by the Department if the health and safety of enrollees is endangered by continuation of an existing contract. The Department will approve or disapprove a contract within thirty (30) days after its receipt from the MCO. The Department may extend this period by providing written notification to the MCO if in the Department's sole opinion additional review or clarification is needed. Network provider contracts shall be deemed approved if the Department fails to provide notice of extension or disapproval within thirty (30) days.

The Department will review each type of contract for services before contract signing. The MCO shall initially submit each type of contract for services with this Contract in the Attachments. The Department's review of the contracts will ensure that the MCO has inserted the following standard language in all network provider contracts (except for specific provisions that are inapplicable in a specific MCO management subcontract):

(MCO's name) (Hereafter referred to as "MCO") and its intended Network Provider, (Insert Network Provider's Name) (hereafter referred to as "Provider"), agree to abide by all applicable provisions of the Contract (hereafter referred to as Medicaid VALTC contract) with the Department of Medical Assistance Services. Provider compliance with the Medicaid contract specifically includes but is not limited to the following requirements:

No terms of this contract are valid which terminate legal liability of the MCO in the Medicaid Contract.

Provider agrees to participate in and contribute required data to MCO's quality improvement and other assurance programs as required in the Medicaid contract.

Provider agrees to abide by the terms of the Medicaid contract for the timely provision of emergency and urgent care. Where applicable, the Provider agrees to follow those procedures for handling urgent and emergency care cases stipulated in any required hospital/emergency department Memorandums of Understanding signed by the MCO in accordance with the Medicaid contract.

The Provider agrees to submit MCO utilization data in the format specified by the MCO, so the MCO can meet the Department specifications required by Medicaid contract.

The Provider agrees to comply with all non-discrimination requirements in Medicaid contract.

The Provider agrees to comply with all record retention requirements and, where applicable, the special reporting requirements on sterilizations and hysterectomies stipulated in Medicaid contract.

The Provider agrees to provide representatives of MCO, as well as duly authorized agents or representatives of the Department, the U.S. Department of Health and Human Services, and the State Medicaid Fraud Unit access to its premises and its contract and/or medical records in accordance with Medicaid contract. Provider agrees otherwise to preserve the full confidentiality of medical records in accordance with Medicaid contract.

The Provider agrees to the requirements for maintenance and transfer of medical records stipulated in Medicaid contract. Provider agrees to make medical records available to recipients and their authorized representatives within ten (10) working days of the record request.

The Provider agrees to ensure confidentiality of family planning services in accordance with Medicaid contract, except to the extent required by law, including, but not limited to, the Virginia Freedom of Information Act.

The Provider agrees not to create barriers to access to care by imposing requirements on recipients that are inconsistent with the provision of medically necessary and covered Medicaid services.

The Provider agrees to clearly specify referral approval requirements to its providers and in any sub-subcontracts. Additionally the Provider agrees to hold the recipient harmless for charges for any Medicaid covered service. This includes those circumstances where the provider fails to obtain necessary referrals, preauthorization, or fails to perform other required administrative functions.

The Provider agrees not to bill a Medicaid enrollee for medically necessary services covered under the Medicaid contract and provided during the enrollee's period of MCO enrollment. This provision shall continue to be in effect even if the MCO becomes insolvent. However, if an enrollee agrees in advance of receiving the service and in writing to pay for a non-Medicaid covered service, then the MCO, MCO provider, or MCO subcontractor can bill.

The Provider must forward to the MCO medical records, within ten (10) working days of the MCO's request.

The Providers shall promptly provide or arrange for the provision of all services required under the provider contract. This provision shall continue to be in effect for subcontract periods for which payment has been made even if the provider becomes insolvent until such time as the enrollees are withdrawn from assignment to the provider.

Except in the case of death or illness, the Provider agrees to notify the MCO at least thirty (30) days in advance of disenrollment and agrees to continue care for his or her panel enrollees for up to thirty (30) day after such notification, until another PCP is chosen or assigned.

The Provider agrees to act as a PCP for a predetermined number of enrollees, not to exceed the panel size limits, to be stated in the network provider contract.

The MCO agrees to pay the Provider within thirty (30) days of the receipt of a claim for covered services rendered to a covered enrollee unless there is a signed contract with the Provider that states another timeframe for payment that is acceptable to that Provider.

Notwithstanding any other provision to the contrary, the obligations of Virginia shall be limited to annual appropriations by its governing body for the purposes of the subcontract.

B. Network Provider Contract Supplement

The Department recognizes that the MCO may use a Provider Manual as a supplement to the Provider Contract. Under that condition, it must be understood that the Contract takes precedence over any language in the Provider manual. The Contract must reference the Provider Manual and identify it as part of the Provider Contract. The Manual must contain language that states the Manual, revisions, and amendments to it are part of the Provider Contract.

If the MCO uses the Provider Manual as a supplement to the Provider Contract, all sections pertaining to Medicaid must be submitted to the Department for approval on an annual basis.

C. Review and Approval of New Provider Contracts and In Approved Subcontracts During The Contract Period

New contracts and changes in approved contracts shall be reviewed and approved by the Department before taking effect. Contracts will be considered approved if the Department has not responded within thirty (30) consecutive days of the date of Departmental receipt of request.

This review requirement applies to changes that affect the amount, duration, scope, location, or quality of services. In other words, technical changes do not have to be approved.

Changes in rates paid to subcontractors do not have to be approved. However, changes in method of payment (e.g., fee-for-service, capitation) must be approved by the Department.

The MCO shall submit to the Department within thirty (30) days of the end of the quarter, its current provider network.

Subcontracts with State Agencies or political subdivisions shall be excluded from the requirements of this addendum to the extent excluded elsewhere in the Contract.

APPENDIX K Certification of Data

CERTIFICATION OF ENCOUNTER DATA RELATING TO PAYMENT UNDER THE MEDICAID PROGRAM

Pursuant to the contract(s) between Virginia and the (enter name of business entity) managed care organization (MCO), the MCO certifies that: the business entity named on this form is a qualified provider enrolled with and authorized to participate in the Virginia Medical Assistance Program as a MCO, (insert Plan identification number(s) here). The (enter name of business) MCO acknowledges that if payment is based on encounter data, Federal regulations at 42 CFR 438.600 (et. al.) require that the data submitted must be certified by a Chief Financial Officer, Chief Executive Officer, or a person who reports directly to and who is authorized to sign for the Chief Financial Officer or Chief Executive Officer.

The MCO hereby requests payment from the Virginia Medical Assistance Program under contracts based on encounter data submitted and in so doing makes the following certification to Virginia as required by the Federal regulations at 42 CFR 438.600 (et. al.).

The (enter name of business) MCO has reported to Virginia for the month of (indicate month and year) all new encounters (indicate type of data such as – Mental Health – Institutional, Mental Health – Professional, Medical – Institutional, Medical – Professional, Pharmacy, Transportation, Dental, Vision, Laboratory). The (enter name of business) MCO has reviewed the encounter data for the month of (indicate month and year) and I, (enter Name of Chief Financial Officer, Chief Executive Officer or Name of Person Who Reports Directly To And Who Is Authorized To Sign For Chief Financial Officer, Chief Executive Officer) attest that based on best knowledge, information, and belief as of the date indicated below, all information submitted to Virginia in this report is accurate, complete, and truthful.

NO MATERIAL FACT HAS BEEN OMITTED FROM THIS FORM. I, (enter Name of Chief Financial Officer, Chief Executive Officer or Name of Person Who Reports Directly To And Who Is Authorized To Sign For Chief Financial Officer, Chief Executive Officer) ACKNOWLEDGE THAT THE INFORMATION DESCRIBED ABOVE MAY DIRECTLY AFFECT THE CALCULATION OF PAYMENTS TO THE (Enter Name of Business) MCO. I UNDERSTAND THAT I MAY BE PROSECUTED UNDER APPLICABLE FEDERAL AND STATE LAWS FOR ANY FALSE CLAIMS, STATEMENTS, OR DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT.

Furthermore, by signing below, the Managed Care Organization attests that the paid claim amount is a proprietary field to be held as such by the Department of Medical Assistance Services. The Managed Care Organization states the following as to why protection is necessary: _____
_____. This information shall not be released, pursuant to the authority of the COV sec. 2.2-4342(F), except as required for purposes of the administration of the Title XIX State Plan for Medical Assistance.

_____

(INDICATE NAME AND TITLE (CFO, CEO, OR DELEGATE)
on behalf of

_____
(INDICATE NAME OF BUSINESS ENTITY)

_____
DATE

CERTIFICATION OF DATA (NON-ENCOUNTER)

CERTIFICATION

Pursuant to the contract(s) between Virginia and the (enter name of business entity) managed care organization (MCO), the MCO certifies that: the business entity named on this form is a qualified provider enrolled with and authorized to participate in the Virginia Medical Assistance Program as a MCO Plan, (insert Plan identification number(s) here). The (enter name of business) MCO acknowledges that if payment is based on any information required by the State and contained in contracts, proposals, and related documents, Federal regulations at 42 CFR 438.600 (et. al.) require that the data submitted must be certified by a Chief Financial Officer, Chief Executive Officer, or a person who reports directly to and who is authorized to sign for the Chief Financial Officer or Chief Executive Officer.

The MCO hereby requests payment from the Virginia Medical Assistance Program under contracts based on any information required by the State and contained in contracts, proposals, and related documents submitted and in so doing makes the following certification to Virginia as required by the Federal regulations at 42 CFR 438.600 (et. al.).

The (enter name of business) MCO has reported to Virginia for the period of (indicate dates) all information required by the State and contained in contracts, proposals, and related documents submitted. The (enter name of business) MCO has reviewed the information submitted for the period of (indicate dates) and I, (enter Name of Chief Financial Officer, Chief Executive Officer or Name of Person Who Reports Directly To And Who Is Authorized To Sign For Chief Financial Officer, Chief Executive Officer) attest that based on best knowledge, information, and belief as of the date indicated below, all information submitted to Virginia is accurate, complete, and truthful.

NO MATERIAL FACT HAS BEEN OMITTED FROM THIS FORM. I, (enter Name of Chief Financial Officer, Chief Executive Officer or Name of Person Who Reports Directly To And Who Is Authorized To Sign For Chief Financial Officer, Chief Executive Officer) ACKNOWLEDGE THAT THE INFORMATION DESCRIBED ABOVE MAY DIRECTLY AFFECT THE CALCULATION OF PAYMENTS TO THE (Enter Name of Business) MCO. I UNDERSTAND THAT I MAY BE PROSECUTED UNDER APPLICABLE FEDERAL AND STATE LAWS FOR ANY FALSE CLAIMS, STATEMENTS, OR DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT.

Furthermore, by signing below, the Managed Care Organization attests that the paid claim amount is a proprietary field to be held as such by the Department of Medical Assistance Services. The Managed Care Organization states the following as to why protection is necessary: _____
_____. This information shall not be released, pursuant to the authority of the COV sec. 2.2-4342(F), except as required for purposes of the administration of the Title XIX State Plan for Medical Assistance.

_____
(INDICATE NAME AND TITLE
(CFO, CEO, OR DELEGATE)
on behalf of

_____
(INDICATE NAME OF BUSINESS)
DATE

APPENDIX L SWAM (Small, Women and Minority-owned Businesses) Utilization Plan

MCO Name: _____ Preparer Name: _____
Date: _____

Is your firm a **Small Business Enterprise** certified by the Department of Minority Business Enterprise? Yes_____ No_____
If yes, certification number: _____ Certification date:_____

Is your firm a **Woman-owned Business Enterprise** certified by the Department of Minority Business Enterprise? Yes_____ No_____
If yes, certification number: _____ Certification date:_____

Is your firm a **Minority-Owned Business Enterprise** certified by the Department of Minority Business Enterprise? Yes____ No_____
If yes, certification number: _____ Certification date:_____

Instructions: *Populate the table below to show your firm's plans for utilization of small, women-owned and minority-owned business enterprises in the performance of the Collection Services contract. Describe plans to utilize SWAMs businesses as part of joint ventures, partnerships, subcontractors, suppliers, etc.*

Small Business Enterprise: "Small business enterprise" shall mean an independently owned and operated business which, together with affiliates, has 250 or fewer employees or average annual gross receipts of $10 million or less averaged over the previous three years. Nothing in this provision prevents a program, agency, institution or subdivision from complying with the qualification criteria of a specific state program or a federal guideline to be in compliance with a federal grant or program. **For purposes of the SWAM Program, the definition of small business enterprise shall be interpreted to include all certified women-owned and minority-owned businesses.**

Woman-Owned Business Enterprise: A business concern which is at least 51 percent owned by one or more women who are U.S. citizens or legal resident aliens, or in the case of a corporation, partnership or limited liability company or other entity, at least 51 percent of the equity ownership interest in which is owned by one or more women, and whose management and daily business operations are controlled by one or more of such individuals. **For purposes of the SWAM**

Program, all certified women-owned businesses are also a small business enterprise.
Minority-Owned Business Enterprise: A business concern which is at least 51 percent owned by one or more minorities or in the case of a corporation, partnership or limited liability company or other entity, at least 51 percent of the equity ownership interest in which is owned by one or more minorities and whose management and daily business operations are controlled by one or more of such individuals. **For purposes of the SWAM Program, all certified minority-owned businesses are also a small business enterprise.**

All small, women, and minority owned businesses must be certified by the Commonwealth of Virginia Department of Minority Business Enterprise (DMBE) to be counted in the SWAM program. Certification applications are available through DMBE at 800-223-0671 in Virginia, 804-786-6585 outside Virginia, or online at www.dmbe.virginia.gov (Customer Service).

1. Plans for utilization of SWAM Businesses					
SWAM Business Name & Address	**SWAM Status: Small (S), Women (W), Minority (M) & DMBE Certif. # & Date**	**Contact Person, Tele. & Email**	**Type of Goods and/or Services**	**Planned Contract Involvement**	**Planned Annual Contract Dollar Expenditure Amount**
Totals $					

APPENDIX M Confidentiality Contract Form

This Contract between the Virginia Department of Medical Assistance Services (DMAS) and _____ (MCO) sets forth the terms and conditions for the disclosure of information concerning Medicare/Medicaid/FAMIS Plus applicants, recipients or providers (Data). For purposes of this Contract, the MCO includes any individual, entity, corporation, partnership, or otherwise, with or without a contractual contract with DMAS, who has been granted permission by DMAS to use or to access Data in DMAS' possession.

Following execution of any contract with DMAS, the selected MCO shall submit a written Security Plan, addressed to the DMAS HIPAA Office of Privacy and Security, describing the manner in which the MCO will use DMAS Data and the procedures the MCO will employ to secure that Data. DMAS HIPAA Office of Privacy and Security will work with the MCO in the preparation of the Security Plan. The uses of DMAS Data detailed in the Security Plan shall not be in violation of purposes directly related to State Plan administration included in 42 C.F.R. § 431.302. The MCO's Security Plan shall be eventually incorporated as Attachment 1 to this Contract. No other uses of DMAS Data outside of the purposes stated in Attachment 1 will be allowed. The MCO agrees to restrict the release of information to the minimum information necessary to serve the stated purpose described in the Security Plan. The MCO agrees that there will be no commercial use of the DMAS data which it receives or creates in fulfillment of its contractual obligations.

The MCO agrees to fully comply with all federal and state laws and regulations, especially 42 C.F.R. 431, Subpart F, and the Code of Virginia , Title 2.1, Chapter 26, (the Privacy Protection Act of 1976) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Access to information concerning applicants or recipients must be restricted to persons who are subject to standards of confidentiality comparable to those DMAS imposes on its own employees and agents. The MCO attests that the data will be safeguarded according to the provisions of the written, DMAS approved, Security Plan meeting the general requirements outlined in Attachment 2. The exact content of the Security Plan will be negotiated between the MCO and DMAS HIPAA Office of Privacy and Security since the general data processing environment of each MCO will be different. In no event shall the MCO provide, grant, allow, or otherwise give, access to the Data in contravention of the requirements of its approved Security Plan. The MCO assumes all liabilities under both state and federal law in the event that Data is disclosed in violation of 42 CFR 431, or in violation of any other applicable state and federal laws and regulations.

The MCO shall dispose of all DMAS Data upon termination of the contract according to provisions for such disposal contained in its Security Plan. MCO certifies that all Data, whether electronic or printed, in any form: original, reproduced, or duplicated, has been disposed of in accordance with the provisions of the Security Plan within thirty (30) days of completion of the project or termination of the contract. No copies, reproductions or otherwise, in whole or in part, in whatever form, of the Data shall be retained by the MCO following completion of the contract. The MCO acknowledges that ownership of the Data remains with DMAS at all times.

A copy of all oral, written or electronic reports, presentations or other materials, in any form, whatsoever based, in whole or in part, on the Data must be reviewed and approved by DMAS prior to its release to any third party.

The MCO will include, on the first page of all materials released to third parties, the following statement: "The following material may contain and may be based, in whole or in part, upon data provided by the Department of Medical Assistance Services, which retains all rights of ownership thereto. No copies or reproductions, electronic or otherwise, in whole or in part, of the following material may be made without the express written permission of the Department of Medical Assistance Services."

The MCO acknowledges that DMAS reserves the right to audit for compliance with the terms of this contract and for compliance with federal and state laws and regulations and for implementation of the terms of the approved Security Plan.

The MCO hereby agrees to comply with all of the requirements set forth herein.

APPENDIX N Data Security Plan

THIS ATTACHMENT supplements and is made a part of the Contract by and between the Department of Medical Assistance Services (herein referred to as "the Department") and [name MCO] (herein referred to as "the MCO").

I. General Requirements

The purpose of these requirements is to provide a framework for maintaining confidentiality and security of data compiled for the Department, the MCO or its subcontractors. This data is the property of the Department.

The MCO shall submit a written contractor Data Security Plan within thirty (30) days of the execution of this Contract by general mail to the Department at the address in this contract. The MCO's Data Security Plan shall describe the manner in which the MCO will use the Department's data and the procedures the MCO will employ to secure the data. The Department's HIPAA Office of Privacy and Security will work with the MCO in the preparation of the MCO's Data Security Plan. The uses of the Department's data detailed in the MCO's Data Security Plan shall not be in violation of purposes directly related to State Plan administration included in 42 CFR § 431.302. No other uses of the Department's data outside of the purposes stated in the MCO's Data Security Plan will be allowed. The MCO agrees to restrict the release of information necessary to serve the stated purpose described in the Contractors Data Security Plan. The MCO Associate agrees that there will be no commercial use or marketing use of the Department's data, which he or she receives or creates in fulfillment of his or her contractual obligations. Upon reasonable request, the MCO shall give the Department access for inspection and copying to the MCO's facilities used for the maintenance or processing of Protected Health Information (PHI), and to its books, records, practices, policies and procedures concerning the use and disclosure of PHI, for the purpose of determining the MCO's compliance with this Contract.

The MCO agrees to fully comply with all federal and state laws and regulations, especially 42 CFR § 431, Subpart F, and Virginia Code Section 2.1-377, et. seq. Access to information concerning applicants or recipients must be restricted to individuals who are subject to standards of confidentiality comparable to those the Department imposes on its own workforce and vendors. The MCO attests that the data will be safeguarded according to the provisions of the written, Department approved, contractor Data Security Plan meeting the general requirements outlined in Part II of this document. The exact content of the MCO's Data Security Plan will be negotiated between the MCO and the Department's HIPAA Office of Privacy and Security since the general data processing environment of each MCO will be different. In no event shall the MCO provide, grant, allow, or otherwise give access to the data in contravention of the requirements of its approved MCO Data Security Plan. The MCO assumes all liabilities under both state and federal law in the event that data is disclosed in violation of 42 CFR § 431, or in violation of any other applicable state and federal laws and regulations.

The MCO shall dispose of all Department data upon termination of the contract according to provisions for such disposal contained in its MCO Data Security Plan. The MCO certifies that all data, whether electronic or printed, in any form: original, reproduced, or duplicated, has been disposed of in accordance with the provisions of the MCO Data Security Plan within thirty (30) days of completion of the project or termination of the contract. No copies, reproductions or otherwise, in whole or in part, in whatever form, of the data shall be retained by the MCO following completion of the contract. The MCO acknowledges that ownership of the data remains with the Department at all times.

II. Format for a Basic Business Associate Data Security Plan

1. State the nature of the requesting organization's relationship with the Department Entity. In the absence of a contract or some other formal contractual relationship with the Department, please provide an explanation of how the proposed use of the Department's data is directly related to State Plan Administration [see 42 CFR § 431.302].

2. Provide the name of the MCO's designated Information Security Officer, including full name, address, phone number and fax number. State the individual's relation to the business function.

3. Provide the names and position designations of all individuals who will have access to the data at or for the MCO.

4. State the exact purpose(s) for which the data will be used.

5. Describe the format (e.g., tape, paper, disk or electronic transfer) in which the MCO envisions receiving the required data from the Department.

6. Describe the medium within the MCO's organization upon which the data will be stored (e.g., will the data be on a disk pack accessible by the MCO's mainframe; will the data reside on a floppy disk stored in a box of similar disks beside the MCO's PC; will the data be accessible to many users through a network on the Internet or on an Intranet?)

7. Describe the provisions the MCO is taking to physically safeguard the Department data in whatever form it has been provided or created. As part of the MCO Data Security Plan for the Department, the MCO must include a copy of any security plan, security policies, or security procedures currently in effect within the organization.

8. Identify all individuals (or entities) to whom the data will be distributed as a result of the business function.

9. Describe through what mechanisms and in what format the MCO proposes to make final work products available to the Department.

10. Summarize, within the MCO's Data Security Plan, the data retention and disposal requirements that exist in the Contract or Contracts with the Department. If the MCO is subject to any other retention requirements, those requirements should be included in the MCO's Data Security Plan.

11. Provide a statement of acknowledgement in the MCO's Data Security Plan that all Department data, no matter how manipulated or summarized remains the property of the Department.

12. Describe the provisions the MCO is taking to ensure continuity of service to the Department in the event of an emergency or other catastrophic event causing contractor business interruption (where applicable).

13. Note the existence of any insurance or bonds carried by the MCO, which would protect the MCO and the Department from contingent liability in the use of the data. Otherwise, provide a statement in the Data Security Plan if no such insurance coverage exists.

DATA SECURITY PLAN EXAMPLE

XYZ ORGANIZATION BUSINESS ASSOCIATE DATA SECURITY PLAN

1. State the nature of the requesting organization's relationship with DMAS. In the absence of a Business Associate Contract or some other formal contractual relationship with DMAS, please provide an explanation of how the proposed use of DMAS data is directly related to State Plan Administration (see 42 CFR, Section 431.302).

   XYZ is the contractor for DMAS contract # XXXX_XX for Preauthorization and Utilization Management Services.

2. Provide the name of the Business Associate's designated Information Security Officer, including full name, address, phone number and fax number. State the individual's relation to the business function.

   Name
   Title
   Organization
   Address
   Phone
   Fax

   Ms. Doe oversees all IT operations at XYZ including connectivity to and data transfer between the DMAS Medicaid Management Information System (MMIS) and XYZ.

3. Provide the names and position designations of all individuals who will have access to the data at or for the Business Associate.

   Associates' name, title, department

4. State the exact purpose(s) for which data will be used.

   1) Medical Review
   2) Report Generation

5. Describe the format (e.g., tape, paper, disk) in which the Business Associate envisions receiving the required data from DMAS.

   Data is submitted from providers by telephone, fax, or mail for medical review purposes and is entered into the internal XYZ databases. Information for all review cases is stored on a XYZ Windows 2000 based server with Oracle 8i as the database management system. Data are backed up to magnetic tape at the end of each business day and stored offsite at X location.

6. Describe the medium within the Business Associate's organization upon which the data will be stored (e.g., will the data be on a disk pack accessible by the Business Associate's mainframe; will the data reside on a floppy disk stored in a box of similar disks beside the Business Associate's PC; will the data be accessible to many users through a network on the Internet or on an Intranet?)

   To ensure confidentiality and security, XYZ maintains a filing process that includes staff assigned for file maintenance, file retrieval, file purging and file preparation for offsite storage. XYZ provides DMAS with access to all files during normal hours of operation.

   XYZ maintains file storage facilities for on-site review of the previous six months of documentation. XYZ maintains offsite storage for files older than 6 months at X storage facility. Files stored at this facility are returned to our location within 24 hours of the retrieval request. Emergency same-day retrieval service is also available.

   Information pertaining to all requests is entered at the Windows 2000 desktop using Visual Basic developed screens and is stored on our Windows 2000 based server with Oracle 8i as the database management system. Data is backed up to magnetic tape at the end of each business day and stored offsite at x location. Access to the server for administrative purposes is limited to the Systems Manager, John Doe, and the Database Administrator, Jane Doe. User access to the system and the case review data is controlled by Windows 2000 security provisions with additional access limitation imposed on the database side via Oracle. Both user ID's and passwords are required for access. Passwords are automatically aged by the system and must be changed by each user every thirty (30) days.

   The Virginia Medicaid system is housed on a Hewlett Packard Pentium III 600 MHz server with 384k memory. Hard disk storage includes a RAID-5 disk array with four – 9.1 KB disk drives, a redundant power supply and tape backup. This system will have the same connectivity to DMAS MMIS as described above.

Data are never sent over the Internet. XYZ uses a secure 'internal' email system. Connectivity to our network is through a LAN in our Richmond office that then accesses our corporate email server via a dedicated frame delay connection line. We do not use Internet email facilities to send any DMAS information. Please refer to the response to question 7 for further information.

   XYZ currently connects to the MMIS at x location via a frame-relay connection from our Richmond office to DMAS.

Future Operating Environment

As required by our new contract with DMAS we will eventually connect to MMIS at X location directly, rather than connecting at DMAS. We will use a serial connection between the XYZ provided

CSU/DSU and the X router. Based on the expected volume, we will provide a 64 KBPS frame relay dedicated data line to the current DMAS Fiscal Agent's data center. In the event that traffic increases significantly, additional bandwidth can be added. At both ends of the frame relay data line, XYZ will provide an ADTRAN TSU LT T1/Fractional T1 CSU/DSU. A public address subnet will be provided if requested by Fiscal Agent for router-to-router connection. There will be a serial router port connection to the CSU/DSU on the Fiscal Agent side of the connection. As required, only public IP addresses will be presented across the data line. No connections across the Internet will be used.

XYZ will employ terminal emulation software – Eicon Access for Windows 3270 – to access the system from our desktop personal computers. Our existing employees and the DMAS contract monitors currently use this software to provide 3270 emulation for access to the DMAS computer system.

While our existing computer system easily and effectively handles all the processing required to support the DMAS requirements, every automated system can be improved. To reduce our maintenance costs, improve system access to DMAS authorized users and improve reliability, we are enhancing our existing Visual Basic/Oracle 8i Based computer system to a configuration that can also employ a browser-based client under Windows 95/98/2000. This browser-based access will use a secure Virtual Private Network (VPN) connection to XYZ's Windows 2000 server supporting the Oracle 8i-database management system. This new environment will make it possible to extend access to the system to any DMAS approved user with access to the Internet, subject to encryption in the manner prescribed in the HCFA Internet Security Policy dated 11/24/1998.

Based on provider interest and approval of DMAS, we will develop ASP based forms to allow providers using their Internet connection to enter data about the pre-authorization request directly from their location – reducing or eliminating the need to fax this information to XYZ. Entry of information by the providers at the source of data to the XYZ maintained database means that errors and processing time associated with printing the fax, routing the fax to the appropriate reviewer and subsequent entry of the information to our computer system are eliminated.

7. Describe the provisions the Business Associate is taking to physically safeguard DMAS data in whatever form it has been provided or created. As part of the Business Associate Data Security Plan for DMAS, the Business Associate must include a copy of any security plan, security policies, or security procedures currently in effect within the organization.

    Our data security and confidentiality plans are summarized and described below.

XYZ is well aware of the confidential nature of the information that we will receive and process, both in paper and electronic format. We also understand that all data provided by DMAS to XYZ remains the property of DMAS. We will use this data only for the activities needed to fully support all the requirements of this scope of work. In the event a need arises for use of the DMAS provided data for some other purpose, XYZ will obtain written permission from DMAS in advance of any use of this data. XYZ also agrees to follow federal and state confidentiality requirements as set forth in the then current Code of Federal Regulations and the then current Code of Virginia.

    To ensure XYZ compliance with all of the confidentiality and security requirements associated with use and storage of health care information, all XYZ employees must adhere to the confidentiality rules and security procedures outlined in the XYZ Employee Notebook.

The notebook is updated as needed but at least every year to reflect current XYZ policies that its employees must adhere to. Every new employee is provided with a copy of the manual, and our Human Resources Department reviews the key section dealing with our confidentiality policy. This section includes information about:

    Access and disclosure of confidential information
    Responsibility for confidentiality vested in a single individual
    Research and statistical reporting
    Legal requests for information
    Disclosure, monitoring, review and evaluation
    Disclosure of privileged data and information to third parties
    Patient access to XYZ data and information

Prospective employee background investigations
Trustee and employee access and training
Document accountability
Building security
Communications security, ADP security
Subcontract requirements
Responsibilities of medical review coordinators
Requests for the generation of non-privileged information
Penalties for disclosure of confidential information

HIPAA mandates new security standards to protect an individual's health information, while permitting the appropriate access and use of that information by health care providers, clearinghouses, and health plans. The standard mandates safeguards for physical storage and maintenance, transmission and access to individual health information regardless of the medium used. In addition to our institutionalization of confidentiality and security policies discussed above, XYZ will comply with all HIPAA data security requirements as needed.
These are some examples of steps we already have in place in:

- We have in place appropriate physical safeguards to protect data integrity, confidentiality and availability. Our offices are secure and require a key or swipe card for entry. Only XYZ employees and four DMAS contract monitors are granted these keys/cards. Visitors to XYZ facilities are required to register and wear visitor's passes. In addition a XYZ employee must escort them. Our computer servers and databases are housed in a locked room within our secure facility. Access to the computer room is limited to information technology personnel. XYZ employees escort maintenance personnel at all times. Smoke detectors and automated sprinkler systems are installed to protect from fire.

- We have developed and implemented administrative procedures to guard data integrity, confidentiality and availability. All employees are required to read and sign a non-disclosure contract as a condition of employment. An employee handbook has been developed that details all employee responsibilities and acceptable conduct and the actions that may be taken in the event of improper conduct. Security awareness training is conducted periodically. All data is backed up on a daily basis and secured in a fireproof safe. Virus detection and correction software is installed on all PCs and corporate servers. Updates to this software are made on a bi-weekly basis.

- We have implemented technical security services to guard data integrity, confidentiality and availability. Access to our local area network and the services available on that network are limited to authorized users. The program manager for each program grants authorization and a unique user id and password are used to gain access. Passwords are automatically retired every thirty (30) days. Access to the automated applications and underlying databases requires a separate logon and password. Access is further controlled on a "need" basis, providing either no access, read only, or write access to data. Users are automatically denied access following 3 failed logon attempts. System logs record user logon attempts, and applications capture information about who has added, modified or deleted records.

- Finally we have implemented appropriate technical security mechanisms that include the processes to prevent unauthorized access to data that is transmitted over a communications network. Our Systems Administrator, who grants access to users only upon program manager approval, controls access to our network. Currently, remote access to our local area network (and thence to the applications and databases) is highly restricted, and is used only from system administration. As we migrate our applications to a "web" ready environment, we will only support dial-in access (to users approved by DMAS) via a limited number of dial up circuits or via the Internet using Virtual Private Network (VPN) technology. VPN supports user authentication via public-private key exchange and provides a secure connection from the remote user to our systems over an encrypted "virtual tunnel" through the Internet.

To ensure that our security policies and practices remain current, we will periodically assess our security risks and vulnerabilities and the mechanisms currently in place to mitigate those risks and vulnerabilities. Measures in addition to those described above will be added as needed.

8. Identify all individuals (or entities) to whom the data will be distributed as a result of the business function.

   Data that identify individual recipients, providers or facilities will never be distributed to any entity outside DMAS except with the express prior consent of DMAS. Aggregated data may be used for provider training, legislative presentations etc., but also only with the prior consent of DMAS. Data may occasionally be requested by HCFA or to other federal oversight authorities for inclusion in multi-state studies, analyses or for other purposes, but again, will not be released without the consent of DMAS.

9. Describe through what mechanisms and in what format the Business Associate proposes to make final work products available to DMAS.

   XYZ will use the mechanisms and formats preferred by DMAS to make final work products available. This may include electronic transmission, tape, diskette, hard copy, or any other medium requested by DMAS.

   Currently the weekly, monthly, quarterly annual and ad hoc reports are sent to DMAS electronically and/or in hard copy format. XYZ does not electronically send any reports to DMAS that contain patient identifiable information.

10. Summarize, within the Business Associate Data Security Plan, the data retention and disposal requirements that exist in the Contract or Contracts with DMAS. If the Business Associate is subject to any other retention requirements, those requirements should be included in the Business Associate Data Security Plan.

    To ensure confidentiality and security, XYZ maintains a filing process that includes staff assigned for file maintenance, file retrieval, file purging and file preparation for offsite storage. XYZ provides DMAS with access to all files during normal hours of operation.

    XYZ currently maintains file storage facilities onsite and available for review for the previous 6 months of documentation. XYZ maintains offsite storage for files older than 6 months at x storage facility. Files stored at this facility are returned to our location within 24 hours of the retrieval request. Emergency same-day retrieval service is also available.

    XYZ shreds all hard copy data that is not stored for retrieval. Any removable magnetic media that has been used for storage is degausses before disposal.

11. Provide a statement of acknowledgement in the Business Associate Data Security Plan that all DMAS data, no matter how manipulated or summarized remains the property of DMAS.

XYZ is well aware of the confidential nature of the information that we will receive and process, both in paper and electronic format. We also understand that all data provided by DMAS to XYZ remains the property of DMAS. We will use this data only for the activities needed to fully support all the requirements of this scope of work. In the event a need arises for use of the DMAS provided data for some other purpose, XYZ will obtain written permission from DMAS in advance of any use of this data. XYZ also agrees to follow federal and state confidentiality requirements as set forth in the then current Code of Federal Regulations and the then current Code of Virginia.

12. Describe the provisions the Business Associate is taking to ensure continuity of service to DMAS in the event of an emergency or other catastrophic event causing Business Associate business interruption (where applicable).

XYZ has instituted a policy detailing our procedures for preauthorization during loss of connectivity. The following policies may be found in our XYZ -- Virginia Operations Policy and Procedures Manual and are also attached to this document.

- Utilization Review (Inpatient) Procedure for Loss of Connectivity.
- Utilization Management (Inpatient) Procedure for Loss of XYZ Database

- Prior-Authorization (Outpatient) Procedure for Loss of Connectivity
- Prior-Authorization (Outpatient) Procedure for Loss of XYZ Database
- Behavioral Health Review Procedure for Loss of Connectivity
- Behavioral Health Review Procedure for Loss of XYZ Database
- Community Based Care Review Procedure for Loss of Connectivity
- Community Based Care Review Procedure for Loss or XYZ Database

13. Note the existence of any insurance or bonds carried by the Business Associate, which would protect the Business Associate and DMAS from contingent liability in the use of the data. Otherwise, provide a statement in the Business Associate Data Security Plan if no such insurance coverage exists.

Our current Managed Care E&O Policy does cover "Medical Information Protection for claims arising out of the inadvertent release of medical information/records." Our underwriter is:

Name
Title
Organization
Address
License #
Phone
Fax

Attachments:
Enclosed are additional documents including Policies and Procedures that XYZ has issued in order to meet the guidelines of the Data Security Plan.